ACCLAIM TOOLKIT

Scaling up Community Involvement in Maternal and Child Health and Prevention of Mother-to-Child HIV Transmission
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How to Use the Toolkit

The Advancing Community Level Action for Improving MCH/PMTCT (ACCLAIM) Project was a three-arm randomized community based trial evaluating the effects of engaging community leaders in MCH/PMTCT, community health fairs (known also as community days) and peer-led health support groups on the demand for, uptake of, and retention in maternal and child health services of pregnant and postpartum women as measured by early ANC attendance (<20 weeks), facility delivery, and infant attendance for child welfare visits six to eight weeks after delivery. The study, funded by the Canadian Department of Foreign Affairs, Trade, and Development (DFATD), involved in-depth interviews with community leaders, community men and women and health workers to better understand the effect of community leader engagement on the demand for and retention of HIV-positive pregnant/postpartum women in MCH/PMTCT services. The study took place in three countries; Swaziland, Uganda and Zimbabwe. Community days and peer-led health support group interventions slightly improved facility deliveries. Engagement with community leaders slightly improved male partner testing, while community days and peer groups improved infant ARV uptake. All interventions improved percentage of attending ANC before 20 weeks gestational age, gestational age at first ANC by 2 weeks and maternal ARV uptake. The Community Leadership intervention had the largest effect on these indicators.

This toolkit is a compilation of Standard Operating Procedures (SOPs), guidelines, curricula and job aids used to implement these three interventions. By sharing this toolkit, The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) hopes the positive effects of ACCLAIM can be recreated in other settings.

Herewith please find a synopsis of what is included in this toolkit:

Community Leaders Tools

Community Leader SOP Manual

The purpose of the SOP Manual is to summarize the targets, purpose, and adaptation of each SOP intended for use by the community leaders. This manual fist gives an overview of how To use each SOP, the activity they are for, and the corresponding forms and reports that should be used with them and then explains the purpose, roles and responsibilities, procedures, and resources of each in detail.

Community Leader Refresher Training Guide

The refresher training is three-day course for community leaders, aimed at improving their acknowledged difficulties with skills and topics, taken from quarterly reports and meetings with EGPAF staff. The refresher training guide provides the step-by-step procedures by which community leaders should engage in community action, advocacy, policies, constructing sustainable plans for change, and certain MNCH topics. The refresher training goes over modules on certain health topics complete with objectives and facilitation instructions. The CLE Refresher Training is intended to equip community leaders with all of the information, structure, and support to assimilate into their roles as leaders in their communities.
Community Leader Forms

The purpose of the Community Leaders Forms is to provide a resource, in which community leaders can give their feedback on the subjects, structure, preparation and implementation of each Community Day. This document also includes forms in which participants can give their feedback on the efficiency and productiveness of their group discussions and of their community leaders.

Module 0-8 Institute

This document provides the goals, key competencies, necessary materials, preparations, timetables, and outlines of each module. Each module is structured by subject and broken down into subsections which include health myths and realities, an overview of national health policies and discussion questions.

SOPs for Adapting the Community Leaders Institute

This document provides a guideline for the adaptation and implementation of the community leaders institute curriculum. This SOP summarizes the skills, training, support, and mentorship that EGPAF staff will provide to the community leaders to best serve their communities.

Community Day Tools

Community Day SOPs

The Community Day SOP outlines how Community Days should be implemented and conducted both by EGPAF staff and local personnel. It addresses the recruitment process, the services that will be provided, the delegation of roles and responsibilities, appropriate conduct, and the correct way to obtain and document data.

Community Day Forms

The purpose of these documents are to establish a method to monitor the registration and attendance of participants and facilitators, agendas for the days, provided services, inventory of equipment, referrals, dialogue templates, exit interviews, and post-meeting plans. These forms serve as an important tool for EGPAF staff and other personnel to use during and after community days.

Male Youth Dialogue Guide

The purpose of this guide is to create an outline for guiding discussions with male youth during Community Days. It is broken up into four subgroups: how they sex, healthy relationships and avoiding HIV, ANC attendance, labor and delivery, and postnatal care/child welfare. Each subgroup comes with accompanying questions that aim to initiate and guide conversation. Establishing this guide for male youth shows the importance placed on changing the mindset and challenging the previous ideas of young males, before or around the time that they begin to engage in sexual activity.

Female Youth Dialogue Guide
The purpose of this guide is to create an outline for guiding discussions with female youth during Community Days. It is broken up into four subgroups: sex, healthy relationships and avoiding HIV, health during pregnancy, labor and delivery, and postnatal care/child welfare. Each subgroup comes with accompanying questions that aim to initiate and guide conversation. Establishing this guide for female youth shows the importance placed on taking preemptive steps towards ensuring that young females understand the importance of pre- and post-childbirth preparation and health.

**Male Adult Dialogue Guide**

The purpose of this Community Day Guide is to create an outline for guiding discussions with male adults during Community Days. It is broken up into three subgroups: ANC attendance, labor and delivery, and postnatal care/child welfare. Each subgroup comes with accompanying questions that aim to initiate and guide conversation. Establishing this guide for male adults shows the importance placed on educating men about HIV/AIDS prevention, how to care for their partner’s and child’s health, and the benefits of joint decision-making.

**Mother-in-law Dialogue Guide**

The purpose of this Community Day Guide is to create an outline for guiding discussions with mother-in-laws during Community Days. It is broken up into three subgroups: ANC attendance, labor and delivery, and postnatal care/child welfare. Each subgroup comes with accompanying questions that aim to initiate and guide conversation. Establishing this guide for mother-in-laws shows the importance placed on educating extended family on how they can help support the health and wellbeing of the women and children in their lives.

**Women at Child-Bearing Age Dialogue Guide**

The purpose of this Community Day Guide is to create an outline for guiding discussions with women of childbearing age during Community Days. It is broken up into three subgroups: ANC attendance, labor and delivery, and postnatal care/child welfare. Each subgroup comes with accompanying questions that aim to initiate and guide conversation. Establishing this guide for women at child-bearing age shows the importance placed on educating women about their own health and that of their child’s.

**Peer Group Tools**

**Peer Group Facilitator Standard Operating Procedures (SOPs)**

The Peer Group Facilitator SOP provides a guideline for the roles and responsibilities of the peer group facilitators. This SOP summarizes the processes by which the peer group facilitator should structure participant recruitment, gathering informed consent, registration, meetings, referrals, withdrawals, and peer group close outs.

**EGPAF Staff Managing Peer Groups**
The EGPAF Staff Managing Peer Group standard operating procedures (SOPs) outlines the procedures and processes by which the maternal, neonatal, and child health (MNCH) and male peer groups should be implemented. Each peer group will have four different sections, on topics including MNCH, gender, PMTCT and their relation to the prevention of HIV and the sustainability of health. This document summarizes the roles, responsibilities, and expectations of EGPAF staff that will ensure the peer facilitators are well-trained and receive the necessary support and mentorship. This document also outlines the procedures that the EGPAF staff should follow in regards to peer group recruitment, participation, attendance, pilot groups and subsequent peer group sessions.

**Peer Group Forms**

This document holds all of the forms, surveys, reports and template materials that will be needed in the peer groups. It includes forms for both the peer facilitators and participants such as registration, attendance, learning needs, training, workshops and mentorship plans. These forms allow the peer facilitators and participants to give their honest feedback on what they thought worked, didn’t work and could be improved upon within the peer group preparation and sessions.

**Peer Groups Manual**

This is an outline of all the sessions that group members who join the groups will be taken through. The sessions aim to capacitate the group members with MCH and PMTCT knowledge so as to change their health behaviour so that better health outcomes will be attained. The MCH classes for women will be taken through the following topics; Staying Health during pregnancy, Pregnancy and birth-planning, Preparing for child birth delivery and immediate post natal care and Staying Healthy after birth. The MCH classes for men will be taken through the following topics; strong informed powerful men as champions for health families, becoming a father, are you ready to be a father and keeping your family healthy.
Community Leader Tools

Community Leader Training Manual

This is the overall training manual for the community leaders. It provides the content on what the community leaders should be trained on. Each module is structured by subject and broken down into subsections which are all important in developing the skills of the community leaders to advocate for better health outcomes in their communities.

CLE Refresher Training

The CLE Refresher Training is aimed at providing community leaders with skills to advocate for the right messages in MCH and PMTCT. This training is done after a year of implementation of this intervention to ensure that leaders are given updates on technical health knowledge.

CLE SOP Manual

SOPs outlines the procedures and processes by which the community leaders intervention should be implemented in order to achieve better health outcomes. This document summarizes how community
leaders should be recruited, trained and mentored. It also outlines the role of the community leader as an advocate and not a teacher of health issues.

Community Leaders Forms

This document holds all of the forms that will be used for managing the community leaders intervention. It includes forms for registration, tracking and documentation of the CL’s work.

Community Leaders’ Manual: Equipping community leaders for social action on health

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Facilitation Tips

Who is a facilitator?

• An individual who makes it easier for the participants
• Good facilitation means juggling lots of responsibilities
• Structures the meeting to be productive and efficient.
• Explains the goals, lays out the agenda, captures contributions
• Summarizes and makes sense of what is being said
• Includes everyone in the process, gets buy-in for the outcomes
• Keeps an eye on the time

Characteristics of a good facilitator

• *Should show humility.* Acknowledge that there is no single source of information and knowledge.
• *Should not be overbearing.* Avoid overpowering the room directly or indirectly. When other participants demonstrate expertise, allow them the opportunity to respond to some questions. Don’t finish other people’s sentences!
• *Should have the ability to learn from participants.* Avoid directly disagreeing with participant responses or having confrontations with participants.
• *Respect for other people, in line with the humanitarian code of conduct.* This includes respect for co-facilitators. When working with community leaders, this should include the proper respectful greetings. Avoid over-familiarization.
• *Should have good control of the room.* When participants are meandering, should be able to steer conversations in the right direction. Facilitators should apply conflict resolution skills when participants engage in heated debate.
• *Recognize that all participants are equal when setting group norms.*
• *Speak in a calm and measured tone, while maintaining projection and energy.*
• *Should apply appropriate etiquette.* Don’t pick the nose or eyes.
• *Should be conservative with his or her mannerisms.* Avoid exaggerated gestures. Avoid pointing at people
• *Should have modest dressing/appearance.* Avoid heavy make-up and perfume, heavy jewelry, tight, revealing, or suggestive clothing and very high heels. Attire should be appropriate and should match the attire participants would be expected to wear.
• *Should be highly organized.* It is important to spend the recommended time preparing for each module. If possible, preparation should be done with the entire facilitation team, no less than the day before the actual activity
• Should use open-ended questions (draw out the ‘why’, ‘how’, ‘what’, ‘who’) rather than closed-ended questions (avoid ones that generate yes/no answers)

Characteristics of a good co-facilitator
• Support the key facilitator and other group members
• Willingness to perform all duties and tasks, including the most humble ones
• Be well informed of the subject
• Maintain consistent eye contact with the facilitator
• Show approval by silent nods, cheer up
• If there is a need to clarify or correct something the key facilitator says, he or she will do so subtly

Preparing for the workshop
• Develop a clear lesson plan with your team
• Practice your presentation points – even if you have presented several times in the past!
• Practice/prepare for the various presentations as a team
• Practice cues and signals as a team

Opening the workshop
• Understand the cultural background - do not impose rules
• Ask participants how they would like to open the workshop. This might include a prayer, a traditional welcome, etc.
• Ensure that all participants are registered but do not commence registration until participants know what they are registering for
• Make sure the introductions are made early
• Ask the participants to share their norms and expectations. These should be focused on the content of the workshop
• Apply ice breakers
• Encourage participation and involvement
• Review the agenda

Workshop killers
• Awkward silence
  The period between starting activities and actually getting everyone on board to begin talking is the most difficult – if not handled appropriately, this can kill the energy of the workshop.
• The dominator
  One individual talking (and sometimes dismissing others’ opinions) can silence other participants.
• The unspoken agendas
  Unspoken concerns and unexpressed dissatisfaction are sure-fire meeting killers. Watch out for cues such as eye rolling, crossed arms and people averting their eyes when you look at them. Give everyone an opportunity to address their concerns and priorities.
Creating an enabling environment
Foster team spirit by ensuring that:

• Communication on what to do, when to do it, how to do it and who will do it is clear and continuous.
• The focus will be more on the benefits the community will receive than on what the project wants.
• You always tell the truth and never commit yourself to beyond what is realistic.
• Be approachable and provide help/coaching/support.
• Listen to ideas, share decision-making authority.

Monitor and evaluate your workshop
• Determine what you want to achieve
• Set clear performance benchmarks
• Identify indicators of success
• Provide opportunities for participant feedback

Participatory approaches methodologies
• Games
• Singing
• Debates
• Drama and role plays
• Skits
• Sorting, ranking and piling
• Drawing and mapping
• Small group work
• Singing
• Storytelling
  Group discussions drawing upon participants’ experiences and knowledge

Materials Needed
Facilitation tools

• One flip chart booklet for each day of the institute
• Cardboard pages for making signs and voting cards
• Index cards with different colors
• Markers (3 – 5 of each different color)
• Notebooks
• Pens
• Two scissors
• One ream of A4 paper for printing
• Printed copies of the stigma booklet
• Name tents (could be improvised out of A4 paper)
• Flip charts with key definitions written in legible sentence case
• Time cards with 30 minute, 15 minute, 1 minute, and time out warnings
• A detailed timekeeper’s schedule with a clear outline of the main sections and the sub-sections
• 15 – 20 copies of the participant handouts (Shona version)
• 15 – 20 copies of the community leaders’ terms of reference
• 15 – 20 copies of the EGPAF brochure
• DVD of the Elizabeth Glaser story
• Sticky tack or masking tape

Key equipment

• Two laptops for note taking and printing
• A printer to make last-minute copies
• Two extension boxes/cables
• A projector
• A camera
• A stop watch
• A chime or bell (for drawing participant attention)

Forms and report outlines

• 4 – 5 copies of the daily registration form
• 15 to 20 copies of the legal release form
• Participant feedback form
• Workshop report outline
## AGENDA

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<td>A vision for better health in our community</td>
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<td>Community Planning for EMTCT and Maternal Health</td>
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**Rights and Health**

2:00 pm – 3:45 pm

- Reproductive Health, MNCH, and PMTCT (contd.)
- 1:45 pm – 3:45 pm

4:00 pm – 5:00 pm

- Reproductive Health, MNCH, and PMTCT (contd.)
- 4:00 pm – 5:00 pm

**AFTERNOON TEA**
Welcome and Overview

Goal
This module aims to help the community leaders have a clear understanding of EGPAF and the key roles they will play.

Key competencies
*By the end of this session, participants will:*
- Demonstrate familiarity with the aims and objectives of EGPAF
- Come to consensus on the terms of reference for participation in EGPAF
- Share their expectations as key stakeholders in the roll out of the EGPAF project

Materials Needed
- Four to six sheets of flip chart paper
- Markers
- Notebooks and pens for participants
- Water proof markers
- Copies of EGPAF project brochure
- Copies of the terms of reference for community leaders involved in EGPAF
- EGPAF Project timeline

Preparations
- Develop lesson plan with activities, roles and responsibilities
- Develop time-keepers schedule, with activities timed in minutes
- EGPAF Country Brochure
- Flip chart papers with full meaning of EGPAF and goals
- EGPAF video
- Handouts with terms of reference for community leaders included

Preparation time
- One hour to develop the lesson plans
- Two hours for group practice

Duration
3.00 hours

Outline
- Opening Remarks and Acknowledgments
  - Introducing the facilitation team
  - Participant introductions
  - Review of agenda
- Section I: Introducing EGPAF
- Section II: Overview of the EGPAF Project
- Section III: Introducing the community leaders’ intervention
FACILITATOR NOTES

This module sets the tone for the entire institute. Facilitators should ensure they spend enough time on this module before moving forward to other parts of the manual. In addition, it is best to have the Health Promotion Unit, Community Nurse, or other member of the district team available to participate in this session. This gives us an opportunity to build a functional relationship with them.

Important issues to reinforce in this introduction include:

- A thorough introduction to EGPAF, including EGPAF’s history. Stress EGPAF’s long history in Country.
- EGPAF works closely with and supports the Ministry of Health and Child Care
- EGPAF is being implemented in three countries
- EGPAF chose to implement EGPAF in Country because the Government is committed to improving health

Introducing EGPAF to participants

In accordance with the Humanitarian Code of Conduct, participants must know that EGPAF includes a research activity to help us know which activities are most effective. However, it is not important to dwell on the research goals and indicators.

It is also important to stress that EGPAF is trying a new approach by working with the resources that already exist in communities. EGPAF believes that the most powerful resource missing from the health sector is not money and the most powerful resource for improving health is communities themselves.

Introducing the community leader intervention

This introduction presents an opportunity to set the stage properly for the entire project. Facilitators should reinforce that EGPAF wants community leaders to take off from where the BCC facilitators have taken off. Communities have been taught a lot by different organizations. Yet, we are not yet seeing the change we believe can happen.

The community leader intervention is intended to support community leaders to take more ownership and control of health activities in their communities. This will include advocating with the political and administrative structures. Most importantly, we want leaders to find practical solutions. We want to mobilize the communities to contribute their resources to implement these solutions and give their time and ideas.

Reminder: It is important to set the tone for this institute by explaining that we believe we have much more to learn from the leaders than the other way around. Stress that what we want to do is to learn for the leaders, and for the leaders to learn from each other.
Part I: Starting the workshop, opening remarks, and acknowledgments

Ask participants how they would like to open the workshop. They may elect to do so with a prayer or with a traditional observance. Give the floor to one of the participants to do this.

Invite the attending district official or the highest ranking participant to give some brief opening remarks (ideally, this person should have been briefed and prepared).

Part II: Introducing the facilitation team

Invite all members of the facilitation team to introduce themselves, including where they come from and what they do. Introduce yourself last, and explain that your role is to ensure that the workshop goes well and meets expectations. This is a natural point to address any outstanding housekeeping issues.

Part III: Icebreaker – Three Truths and a Lie! (Optional)

Explain that we have a special way of doing introductions.

Ask everyone to choose four pieces of information about themselves to share with the group, along with their name. Three of the facts should be true, and one should be a lie. For example, ‘Alfonse likes singing, loves football, has five wives and loves workshops’.

Participants then should circulate around the room and meet in pairs. Participants should introduce themselves with the four statements, and ask their counterparts to guess which of the ‘facts’ is a lie.

After everyone has introduced themselves to at least four other participants, ask people to introduce the person that was introduced to them first, recalling the three true statements and their name.

Part IV: Review of the agenda

Invite a member of the facilitation team to walk the group through the agenda.

Part V: Introducing EGPAF’s history

Ensure that participants understand the full meaning of the acronym (Elizabeth Glaser Pediatric AIDS Foundation). If there is a projector and electricity available, play the EGPAF video. Give enough time for participants to ask questions.

Emphasize that one of the strategies EGPAF uses is to strengthen the family health services so that all families are protected from HIV. This means that families affected by HIV will also receive the support and care they need, while keeping new infections low.

Part VI: Introducing EGPAF’s work in (Country)

Explain that:

Since 2001, EGPAF has supported the efforts of the Government of (Country) to revitalize and strengthen the health system. EGPAF works with health workers, health facilities, districts, provinces, and the Ministry of Health and Child Care. We participate in trainings, medical technologies, policy development and research.
Today, EGPAF supports 1440 of the 1500 facilities in the country, which is represents over 95% of the health sector.

Our goals are:

[Insert EGPAF Country program implementation goal]

Country [Insert EGPAF Country advocacy goal]

Explain that at the moment, EGPAF is supporting the national target of reaching zero new HIV infections in children and making sure mothers don’t die in the process of giving life.

Part VII: Discussing the goals and objectives of EGPAF

Explain to the participants that it is essential to have a thorough overview of EGPAF before the workshop can start. Many of the participants may have already attended community entry sessions in which extensive introductions of the project have been conducted.

Ask if any of the participants have already heard about EGPAF. Select two or three people to share what they may remember about the EGPAF Project, its aims and objectives.

Thank the participants, and explain that you would like to give an overview of the project to give further clarity on what it intends to accomplish and why EGPAF presents a special opportunity for the participants and their communities.

Ensure that you go over the following elements of EGPAF in detail, and allow substantial time for questions and answers from the participants:

Project rationale: We want to learn how interventions can be designed to effectively address the needs of families and communities. We emphasize that in order for mothers and children to have the best health, their health must be everybody’s business, from fathers, in-laws, and neighbors, to the community leaders, and healthcare workers.

Project goals: Our goals are to improve demand, adherence, and use of key health services by all members of the family during pregnancy and in the breastfeeding period.

Project objectives: We believe that if we can address the following issues, we will save many lives in the community:

- We want mothers to complete four ANCs as recommended by the government
- We want all births to be delivered in the health facility
- We want all fathers to also care about their health, and take the necessary tests to protect their wives and babies
- We want all mothers to comply with directions and adhere to any medications they are given
- We want all parents to ensure that children receive the medications they are given
- We want children to come back for a health visit soon after birth
- We want new mothers to come back for a health visit soon after birth

**Project design:** We have some research as part of this program that will help us to test different activities. In this way, we will see what works. For this reason, we will have different activities being implemented in different communities.

**Target audience:** We believe that in order to save lives, health should be everybody’s business. We are working with community leaders first, but we will bring all communities together for sharing. We will also target pregnant women and men who are interested in achieving better health for their families.

**Key interventions:** We will implement a community leaders’ engagement methodology, community days, and peer groups. These interventions will be implemented in a staggered fashion across the various communities. This means that not all communities will receive the same package of interventions.

**Project timeline:** We will be implementing these activities until 2016

**Sustainability:** We want communities to take ownership of the interventions and lead the way starting from the first day, but also after the project ends. We believe this project will start a new page that will continue beyond the 2016 end date.

**Part VIII:** Discussing the rationale of the community leaders’ intervention

Explain to participants that they have been selected by other leaders in their communities to participate in a key intervention. This intervention will improve coordination and enhance the expertise already existing in participating communities.

They have been selected because of the key roles they play in their communities, their previous and current leadership experience, their commitment to community service, and their potential to contribute to positive developments in their communities.

Explain that the key elements of the intervention include the community leaders’ institute, having routine meetings and technical updates with the community leaders, and developing an action plan with practical solutions to the community’s health challenges.

Before commencing other elements of the workshop, it is important that participants understand the entire terms of reference expected of them, and the important role that they will be playing in the success of the project.

Review the terms of reference of the community leadership team in details, allowing time for discussion and responses.
Emphasize some of the benefits of participation (such as increasing their influence and profile, benefiting from exchanges with other communities, participating in special technical topics, finding solutions to problems in their communities, etc.).

However, it is also important to emphasize some of the foreseen challenges of the task ahead:

- Change can be slow to start, and then overwhelming once it initiates.
- Change can be erratic, with the potential for progress and regression in different areas.
- Community expectations can be quite high, and perceptions of personal gain may have to be carefully navigated and addressed.
- It might be necessary to utilize tact, conflict resolution, and negotiation to navigate the perspectives of different constituencies.
- It might be important to take unpopular stances that are a bit ahead of the curve.
- The timeline of the project is limited, so more work may be required earlier in the project.

Spend a few minutes discussing these issues with the participants.

**Part IX: Introducing the community leaders’ institute**

Explain the activity that starts today is the community leaders’ institute. It is the first step in ensuring that the foundation is set right for the entire project. Our desire for the institute is to introduce the EGPAF project to the community leaders. We also aim to begin to explore the challenges that are confronting communities and leading to high deaths among women and children. We will do this by discussing the main Ministry of Health and Child Care programs and policies, and how communities can benefit from them. We will also discuss the role that community leaders have in making sure communities actively organize themselves to benefit maximally. Explain that by the end of the community leaders’ institute, we want community leaders to come to some agreement on the way forward for the EGPAF project.

Further, explain that after this introduction, there will be opportunities to go deeper into these issues through the monthly and quarterly meetings.

**Part X: Recapping the issues (5 minutes)**

Summarize the institute as follows:

Over the next four days, we will start with a short orientation of the different policies and guidelines, and reflect on the roles of leaders in making sure communities benefit. We will also discuss issues like gender inequalities, stigma and discrimination, and how they affect health. We will discuss the worsening health outcomes for children and mothers, including the profile of issues in our community that are important factors. Finally, we will analyze how to move forward.
Participant Handout

Terms of Reference

1. The Community Action Team is comprised of dynamic community leaders such as civil society heads, business owners, health professionals, healthcare providers, religious leaders, local councils, women leaders, traditional leaders, community members, and others interested in and able to take the lead to actively implement community specific, culturally competent actions that will lead to healthier outcomes for all mothers and babies.

2. All members of the community action team will serve in a capacity that upholds the highest standards of professionalism and respect, in working with other team members and community groups to implement change.

3. All participants will agree to serve a minimum of two years, with the option of extending that term of office once completed.

4. The participants will meet quarterly on the [nth day] of the month. All meetings will be held at [specific location] from [00:00hr to 00:00hrs]. All meetings will start and end promptly and as agreed.

5. All participants must, at all times, listen respectfully to each other, ensure that every participant has the opportunity to speak and be committed to resolve differences in opinion respectfully.

6. All participants of the community action team must be able to work actively to implement the plan of action agreed to jointly by the entire membership of the community action team.

7. Each participant will be expected to hold deep and extensive consultations within their organization during planning and feedback periods, and will routinely keep their constituents informed of the progress of the work of the community action team.

8. Each participant will pursue collaborations across the key sectors affecting the health and wellbeing of mothers and children, in a non-partisan, non-confrontational, non-judgmental manner; they will be committed to the highest levels of transparency and inclusiveness possible.

Rights and Health

Goal

The aim of this module is to provide a platform for participant dialogue on health rights and obligations as defined by the State

Key competencies

By the end of this session, participants will:

- Be familiarized with the major policies and frameworks that guide MNCH services in Country
- Display strengthened understanding of the major elements of the right to health and key obligations as defined by the Government of Country
- Brainstorm ideas on how to link household and community-level practices to the generation of health
- Analyze how traditional and religious practices may promote or harm health
• Understand the major elements of the Patient Charter and how it applies in their local contexts

Materials Needed
Module I participant handout package
Flip chart paper (15 to 20)
Scissors
Index cards (2 per participant)
A4 papers
Sticky tack
Markers in different colors
Facilitator Notes

Preparations
Develop lesson plan with activities, roles and responsibilities
Develop time-keepers schedule, with activities timed in minutes
Flipchart papers with major definitions translated into Shona
Flipchart paper for ice breaker three dots and four straight lines

Preparation time
One hour to develop the lesson plans
Two hours for group practice

Duration
3.45 hours

Outline
Section I: The Right to Health - National Policies and Strategic Plans
Section II: The Right to Health - Main Frameworks and Concept
FACILITATOR NOTES

This module strives to encourage good relationships between community leaders, their communities and the health system. It also strives to set the tone for communities to take ownership and active participation in addressing health challenges. Discussions around the right to health run the risk of being hostile. Facilitators should be vigilant and proactive about managing and controlling the group. In addition, it is best to have the Health Promotion Unit, community nurse or other member of the district team available to support this session.

Reminder: Brief the HPU on the objectives of the program prior to starting the activities.

Historical perspective

The main elements of the right to health context were set forth in the Alma Ata declaration of 1978 (Annex 1). The modern foundations of Primary Health Care draw upon this work.

The Country Patient’s Right Charter was developed in 2000. It specifies the major rights, obligations and services available to patients.

Applying this in the institute

The definition of the right to health can be misunderstood. It is important to specify that the highest attainable standard of health is context-specific (not absolute). In reviewing the patient’s charter, it is important to stress both the rights communities have to care, and their obligations and responsibilities to ensure their own health and good health for all.

Handling questions from the communities

Communities provided extensive feedback during formative assessments. They shared a number of issues. Facilitators should be prepared to respond to these. The responses should be brief and simple. Below are some questions the communities have asked:

Q: The major frameworks indicate that patients cannot be turned away if they are in need of health services. Yet, people get turned away by the health facilities. Isn’t this a violation of their rights?

A: The Country patient’s charter, which was developed by the Ministry of Health and Child Care, clearly states that patients should not be turned away if they are in need of services. However, a number of issues may occur at health facility level:

- Women may be referred if the facility lacks sufficient resources to attend to their needs. Often, this may be misunderstood as refusal to provide care.
  
  Health facilities may be affected by shortages of infrastructure, which might make it unsafe for women to stay. For instance, water shortages in arid areas may make it
difficult to maintain hygiene, electric power outages might make it difficult to operate, and security issues might jeopardize patient and staff safety.

Q: We indicate that people should have a right to health services regardless of their ability to pay. In our community, they are often asked to pay and refused services if they cannot. Isn’t this a violation of their rights?

A: The Country Patient Charter states that patients should be guaranteed services regardless of ability to pay. However, it does not guarantee that all services will be free. The only free services the government guarantees are:

- Immunization services for children,
- Immunization services for pregnant women
- Treatment for mental illness

Despite this, patients have an available recourse if the cost of health services is a barrier. Patients can:

- Secure a letter from their village head that confirms their inability to pay
- Secure a letter from the social work department that confirms their inability to pay
- Make arrangements with the health facility to develop a long term payment plan

Q: If the Country Patient’s Charter indicates that services should be available regardless of the ability to pay, why do health facilities charge for their services?

A: The government fully subsidizes the services of some public facilities. However, local, council, and municipality clinics only get grants that amount to 30% of what would be given to a similar public facility. It is expected that these facilities will fundraise in order to raise the gap. This is why some costs may be passed on to patients.

Q: The major frameworks indicate that patients should get quality care, but women are often treated very harshly by health workers. Where can a woman, family, or community lodge complaints if have they experience this?

A: If a woman experiences incompetent, harsh, or humiliating care, the health worker can be reported to the appropriate offices, including facility management, district medical officer, and/or the health professions council of the country.

Handling the presence of the health team:

If the facility or district health team staff attend this module, it is important that the facilitator proactively manage and prevent any confrontations and accusations. If possible,
Part I: Ice Beaker - Nine Dots Straight Line

First prepare the nine dots on flip charts, arranging the dots in a square matrix of three rows and three columns. Ask the participants to come in turns to join the nine dots using only four straight lines, without lifting their hand. After they have tried and failed to join the dots, ask them to help each other and try to join the dots as a group. Solve the riddle if necessary.

Once it is solved, ask participants to reflect on the meaning of the riddle. Entertain all responses. Explain that the riddle shows us that if we think outside of the box, we can creatively solve impossible questions (another alternative meaning of this activity can be provided: If participants reflect closely on the solution, it looks like an umbrella, symbolizing that fact that we all are under the same umbrella, working jointly to create solutions).

Part II: Introduction to the module on rights and health

Achieving health is a two-way process. Services need to be available, but they also need to be engaged responsibly. Often, the biggest barriers to better health for mothers and children are at the household and community level. Some groups in the community may have poorer health because they have limited understanding of the main national frameworks. Therefore, it is important for communities to understand their role in health. A key aim of EGPAF is to help people understand the main health challenges affecting their communities and highlight ways that they can be solved at the local level.

Part III: Introduce the main national policies

Explain that in country, our government has put policies in place to reinforce the national health sector. Some of these policies are specific to the health of women and children. There are also important policies that strengthen the health sector as a whole. Ask participants to name any specific policies that they may be familiar with.
Hang up the flipcharts with the list of health policies. Go through the list of the health policies, referring participants to the appropriate pages in their handouts.

They include:

- Zimbabwe Maternal and Neonatal Health Road Map 2007 – 2015
- Zimbabwe National Health Strategy 2009 – 2013
- Zimbabwe eMTCT Strategic Plan 2011 – 2015
- Zimbabwe National HIV & AIDS Strategic Plan (ZNASP 2) 2011 – 2015
- Zimbabwe National Gender Policy 2013 – 2017

Explain that taken all together, they aim to reinforce the national health sector.

Briefly summarize each policy as follows (Using Zimbabwe as an example):

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Country Maternal and Neonatal Health Road Map 2007 – 2015</strong></td>
<td>This policy includes the major strategies and inputs (such as equipment, medicines) needed to stop death rates among pregnant women and their children from rising.</td>
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<tr>
<td><strong>Country National Health Strategy 2009 – 2013</strong></td>
<td>The theme of the NHS is ‘Equity and quality in health: A people’s right’. It addresses the critical staff, laboratory infrastructure, health infrastructure, medical products, vaccines, technology, transport and communication necessary to address the country’s burden of disease.</td>
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<tr>
<td><strong>Country eMTCT Strategic Plan 2011 – 2015</strong></td>
<td>This plan sets an ambitious target to reduce the number of children who get AIDS in the perinatal and breastfeeding period to almost zero, by 2015. It includes clear roles for the community and community leaders to support the effort to reduce child deaths and illness from HIV.</td>
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<tr>
<td><strong>Country National HIV &amp; AIDS Strategic Plan 2011 – 2015</strong></td>
<td>The two work together with the Country eMTCT strategic plan to identify a multi-sectorial road map for achieving strengthened comprehensive prevention, care and treatment services at all levels for all people living with HIV in country. This plan aims to reduce all new infections by 50%, reduce deaths due to HIV by 38% and ensure that the national response is better coordinated.</td>
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<tr>
<td><strong>Country National Gender Policy</strong></td>
<td>Though written by the Ministry of Youth Development, Gender, and Employment Creation, the Country National Gender Policy has a segment on Gender in Health and HIV and AIDS. The policy recognizes that poor health and HIV and AIDS impacts women more negatively than men and aims to protect the right to healthcare for women and equality in health delivery.</td>
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<tr>
<td><strong>Country Patient Charter</strong></td>
<td>Was introduced in 2000. Sets forth the major elements of patients’ rights to healthcare and humane treatment; patients and family responsibilities and obligations; the services available within the health sector; the list of free services in country.</td>
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Explain that handouts describing related national packages such as the essential maternal, neonatal and child health services and the sexual and reproductive healthcare package are available in their handout packages for further reference.

**Part IV: Discussion on health system constraints and community expectations**

1. Ask whether participants who have held advisory, administrative or collaborative roles with the health system to identify themselves. Divide the group into several small groups of seven to eight individuals, taking care to ensure equal representation in each group, of individuals who have some perspective on the health system and, in particular, the operations of the health facilities in their area.

2. Ask participants to discuss their views on the barriers that the health system faces. Note that very often, community members expect a lot from the health sector, without appreciating health providers’ constraints. Ask participants to reflect on the following:
   a. Given the objectives of the strategic policies/plans shared above, how well equipped are the local health units that they are familiar with?
   b. What are some of the limitations that constrain better health provision at sites?
   c. What has been observed about the staff levels, drug supplies, drug costs, laboratory services, client flow, facility adequacy, strikes/industrial action, etc.?

3. Ask participants to discuss some of the managerial challenges and weaknesses they may be familiar with.

4. Ask participants to consider what the expectations of community members are, and how and whether these expectations can be met given the constraints and realities discussed above. Are there specific actions that the communities could take to support health facilities and health staff? Are these already ongoing? What are some examples? What strategies and key messages might potentially help to manage community expectation without dampening demand and enthusiasm for critical services?

5. The key points to draw from this discussion include the following:
   a. Often, the expectations of community members are high.
   b. Community members may not be aware of the constraints and realities health facilities face.
   c. Communities could take specific actions to support health facilities and health staff.
   d. With more understanding of the levels where services are available, communities could be guided to access appropriate and essential care.

**Section Two: The Right to Health Main Frameworks and Concepts**

**Part V: Introducing the section on the main health rights frameworks**

1. Explain that very few communities are aware of the provisions in the national policy documents, as well as their obligations and responsibilities. Community leaders have a key role in bridging the gaps between communities and facilities. Part of this is helping communities understand the rights and roles that the MOH recognizes.
Part VI: Discussing the main frameworks on rights and health

1. Explain that our Government recognizes the right to quality health.
2. Ask participants how they would define health. After a few contributions, share and explain the following definition:

   “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

3. Next, ask participants what the right to health means to them. Share and explain the following definition:

   “The right to health is the right to the highest attainable standard of health.”

   a. Clarify that the ‘highest attainable standard’ is specific to the local context. This includes what the government can reasonably afford. Also, with rights come obligations and duties. It is impossible to talk about the individual’s (or the community’s) right to health without also discussing their obligations and duties. Place flipcharts with these definitions on the walls so that participants can reflect on them from time to time.

Part V: Reviewing the Country National Patient’s Charter

1. Explain that our government introduced the National Patient’s Charter in 2000, in order to allow the Ministry of Health to:
   a. Listen to and act on people’s views and needs
   b. Set optional standards of health services
   c. Provide health services which meet these standards

2. Further, the charter explains about:
   a. The kind of service you can expect from the health care delivery system
   b. Your rights
   c. Your responsibilities and obligations
   d. How you can feedback on the quality of services you are provided

3. Distribute the Country National Patient Charter, ensuring that each participant has a copy.

4. Summarize the content of each section, pausing for questions and contributions at the end of each section.

Section Three: Communities and Social Structures and Rights and Duties

Part VI: Facilitate a discussion on the rights and responsibilities of communities.

1. Explain that sometimes, major denials of the right to health occur at the household level. This could be because of ignorance, entrenched practice or lack of awareness. Individuals and communities have a codified role in ensuring health. Many major denials could be reversed with adequate awareness at the community level. As such, it is important to discuss the role of communities in
securing health.

2. Also explain that the national instruments are clear on the duties and obligations of the health system. Any discussion of rights and duties, however, is not complete if the duties and obligations of communities are not discussed.

3. Ask participants to reflect on issues at the community levels that prevent the full attainment of health, including knowledge, practice, attitudes and norms.

4. Next, ask participants to reflect on their role in supporting the major policy instruments and the right to health. Ask them what they have done in the past for women and children in particular and what else could be done in the future.

5. Facilitate the group discussion to touch on:
   a. The extent of use of traditional health, particularly during labor and delivery
   b. The reasons why people may be more comfortable using traditional health practitioners
   c. Some of the ways traditional systems and indigenous knowledge could be brought online as partners
   d. A summary of the key messages and reasons why traditional health practitioners may want to encourage pregnant women and their families to seek health services
   e. An explanation of the role and influence of religious communities and congregations

Part VII: Recap

1. Summarize the module as follows:
   a. Communities comprise an important part of the health system for various reasons: they generate values and belief systems that can promote or sanction important individual health and social behaviors; they organize to provide important safety nets in times of crisis and need; they provide the critical inputs that ensure individual health and wellness, including first level care at the household level.

2. As we have realized, communities, their leadership, their social structures and their networks, hold the key to achieving good health for all. We have heard what you think about this.

3. Next, we are going to discuss how various inequalities and inequities prevent different groups from attaining the right to health. We will also explore how the social behaviors in our communities prevent us from reaching the various national health goals. We will discuss such issues such as gender inequality, stigma, and discrimination.
Module 1: Participant Handout Package

Elements of the sexual and reproductive health package

4.2.2 Services at the Clinic level.

IEC

- Gender equity
- Prevention of STIs and HIV/AIDS
- Cultural and religious issues
- Menopausal/andropausal/geriatric issues
- Sensitising men and boys to RH
- Community action against physical/sexual violence

Safe Motherhood

Prenatal care.

- Counselling on breast feeding and breastfeeding options, nutrition, birth spacing etc.
- Referral for complications of pregnancy (hypertension, pre-eclampsia, eclampsia, severe anaemia, malaria, APH, CPD).
- Detection and treatment of women with STIs and RTIs.
- Prophylaxis for tetanus, malaria and anaemia.

Delivery care.

- Normal delivery.
- Detection of complications of delivery, initial management and referral for hospital delivery.
- Upgrading facilities to offer basic emergency obstetric care.

Post partum care.

- Provision of early post partum care.
- Breast feeding support and early bonding.
- Provision of breast milk substitutes to HIV positive mothers where applicable.
- Birth spacing and counselling services.
- Provision of nutrition education and supplements.
- Identification and initial treatment of puerperal sepsis.
- Management of mild to moderate of asphyxia of the newborn and neonatal hypothermia.

Family Planning

- Information on sexuality and gender, education and counselling.

- Community mobilisation and education of adolescents, youth, men and women.
- Provision of free oral contraceptives, injectables and condoms and appropriate referrals.
- Referral for tubal ligation.
- Insertion of IUCD after screening for contraindications.
- Counselling for women with post abortal complications.

Prevention and treatment of STIs and RTIs.

- Provision of free condoms.
- Referring clients for VCT
- Application of syndromic management protocols for STIs and RTIs.
- Partner notification and treatment.
- Coordinating home-based care for AIDS patients.

Adolescent reproductive health.

- Provision of information and services in a youth friendly manner.

Malignancies of the reproductive organs.

- Pap smears and UVI for cancer of the cervix.
- Teaching self-examination for cancers of the breast, prostate, testicles and penis.
- Early referral for suspicious cases.

Infertility

- Counselling and referral of appropriate cases.

Menopause and andropause

- Identification and referral of those with problems.

Physical and Sexual violence

- Early referral of cases to district hospital and police.

Provider skills

- Ensuring there is a trained midwife at every clinic.
- Equipping staff with IEC skills to interact with the community and its leaders.
Elements of the Maternal and Child Health Package

1. Adolescent Sexual and Reproductive Health
   - Provide youth friendly sexual and reproductive health services
   - Educate adolescents about sexual and reproductive health and rights in a life skills context
   - Refer youth for sexual and reproductive health services as appropriate

2. Family Planning including PMTCT of HIV
   - Provide information on family planning services (sources)
   - Provide counselling on family planning including dual protection
   - Provide appropriate family planning services including male and female condoms within the context of a National Comprehensive Condom Program
   - Provide emergency contraception
   - Provide ARV prophylaxis for rape victims
   - Refer clients for specialist services that you cannot provide
   - Provide HIV counselling
   - Provide HIV testing

3. Antenatal Care including PMTCT of HIV
   - Provide counselling on pregnancy
   - Provide counselling on STIs
   - Provide counselling on nutrition and breastfeeding
   - Provide counselling on family planning
   - Nutrition for the pregnant mother (balanced diet)
   - Referrals for emergency complications
   - Detect women with STI’s
   - Treat women with STI’s
   - Provide prophylaxis for Tetanus
   - Provide prophylaxis for Anemia (iron and folic acid)
   - Provide prophylaxis for Malaria (Intermittent Preventive Treatment 1,2,3)
   - Detect complications of pregnancy
   - Manage selected cases and refer appropriately
   - Maintain and distribute appropriate drugs and supplies
   - Provide HIV Testing
   - Manage complications of pregnancy and refer appropriately

4. Delivery Care including EmONC
   - Perform normal deliveries
   - Detect complications of delivery and refer appropriately
   - Manage complications of delivery
   - Provide HIV counseling
   - Provide HIV testing
   - Provide ARVs for PMTCT
• Provide Basic Emergency Obstetric and Neonatal care
• Provide Comprehensive Emergency Obstetric and Neonatal care
• Arrange transport for obstetric emergencies to next level of care
• Follow up of referred of obstetric and neonatal emergencies

5. **Postpartum Care including PMTCT of HIV**
• Provide early postpartum care up to six weeks
• Support exclusive breastfeeding
• Counsel for and provide contraceptive condoms
• Provide nutrition education and supplements
• Identify puerperal and neonatal complications and refer appropriately
• Manage rare neonatal problems and provide feedback about referred cases

**Country Patient Charter**

The Patient Charter aims to improve the relationship between patients and health care providers by helping or allowing the Ministry of Health and Child Welfare to:

• Listen to and act on people’s views and needs
• Set optimal standards of health services
• Provide health services which meet these standards

The charter explains:

• The kind of service you can expect from the health care delivery system
• Your rights
• Your responsibilities and obligations
• How you can give feedback on the quality of services you are provided

**1. 1 Right to health care and humane treatment**

1.1.1 Every individual shall have access to competent health care and treatment regardless of age, sex, ethnic, origin, religion, political affiliation, economic status or social class.

1.1.2 Health care services shall be available on the basis of clinical need regardless of the ability to pay and it shall be the responsibility of the government to ensure the every person has access to essential health services

1.1.3 Every patient shall be treated with care, consideration, respect and dignity without discrimination of any kind

1.1.4 All drugs and vaccines shall be of acceptable standards in terms of quality, efficacy and safety

1.1.5 In an emergency, every individual shall have the right to prompt treatment from the nearest medical/health facility
1.1.6 A child admitted to the hospital shall, whenever possible, have the right to the company of a parent or guardian.

1.2 Confidentiality

1.2.1 A patient shall have the right to the details of his or her treatment (including the use of new technology), prognosis and all communication and other records relating to the patient’s care to be treated as confidential, unless:

- Authorized in writing by the patient
- It is undesirable on medical grounds to seek a patient’s consent, but it is in the patient’s own interest that confidentiality should be broken
- The information is required by due legal process

1.3 Privacy

1.3.1 Patients shall be interviewed, examined and treated in surroundings designed to ensure reasonable privacy and shall have the right to be accompanied during any physical examination or treatment if they wish.

1.4 Right to Choice of Care

1.4.1 A patient shall have right to a second opinion at any time while consulting the same medical or health care delivery system.

1.4.2 A patient or next of kin shall have the right to a copy of his or her case history and medical records and have them explained. The patient or next of kin shall also have the right to authorize, in writing, permission for a health professional to obtain a copy of his or her history and records and to inform him or her of what they contain.

1.4.3 If a patient’s health professional refuses to allow another health professional to be called in, or if he or she breaches any other provisions of this charter, the patient shall have the right to seek alternative service/care or even take the issue to the Health Professions Council.

1.5. Right to Safety

1.5.1 A patient, if not incapacitated, shall have the right to a clear, concise explanation of the terms of the proposed procedure and of any available alternative procedure before treatment or investigation. The explanation shall incorporate information on risks, side-effects, problems relating to recuperating, likelihood of success, risk of death and the proposed administration procedure. The patient should accept the consequences of doing so.

1.5.2 It is a requirement that clients or patients accept treatment in cases where the condition may affect the wider public.
1.6  **Right to adequate information and consent**

1.6.1 A patient shall have the right to know the identity and professional status of the individuals providing service to him/her and to know which health professional is primarily responsible for the patient’s care including:

- The right to adequate and coherent information on prescribed and purchased medicines.
- The right to choose among competitive products based on unbiased information.
- The right to know his or her prognosis and everything about his or her medical problem.
- A patient’s written consent shall be required for the inclusion of his or her participation in any research or teaching program. The patient shall be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. The patient shall be informed that he or she is at liberty to abstain from participating in the study and that he or she is free to withdraw his or her consent to participation at any time.
- To ensure that the informed consent is not obtained under duress or from a patient in a dependent relationship to the health professional, the informed consent shall be obtained by a health professional who is not engaged in the investigation and who is completely independent of the official relationship between the patient and the health professional. In the case of a child, the informed consent shall be obtained from a parent or guardian.

1.7  **Right to Redress of Grievances**

1.7.1 A patient shall have access to appropriate grievance handling procedures bearing in mind that all health care delivery professions are not super humans.

1.7.2 A patient shall have the right to claim for damages for injury or illness incurred or aggravated as a result of the failure of the health professional to exercise the duty and standard of care required of him or her while treating the patient.

1.7.3 A patient shall have the right to legal advice in regard to any malpractice by a health care professional.

1.8  **Right to Participation and Representation**

1.8.1 A patient shall have the right to participate in the decision-making process that affects his/her health:

- With the health professionals and other support staff involved in direct health care.
- Through consumer representation in planning and evaluating the system of health services, the types and qualities of services, and the conditions of service under which health services are or were delivered.
- To give an assessment of the quality of services offered to him/her.
1.9 **Right to Health Education**

Every individual shall have the right to seek and obtain advice with regards to preventive and curative medicine, after care and good health.

2.0 **The Right to a Healthy Environment**

Every individual shall have the right to an environment that is conducive to good health. This includes and extends to health professional’s office, health center, hospital room and any other facilities.

2.1 **Patient and Family Responsibilities**

2.2 While the patient has the right to be heard, he/she also has an obligation to listen to medical instruction concerning your treatment.

2.3.1 The patient and family shall provide accurate and complete information to assist the health professional in planning for stay and treatment.

2.4 The patient and family shall produce proof for their inability to pay for healthcare services, except in emergency cases as determined by the healthcare professionals.

2.4.1 To avoid inconveniences to himself/herself and to others, the patient should follow the referral chain and ensure that he/she has the necessary documents to affect his/her access into hospital.

2.4.2 Keep his/her hospital notes safe and clean as he/she will need them during his/her next visit or contact with the health services.

2.4.3 The patient and family shall ensure that he/she understands the purpose and cost of any proposed investigations or treatment before deciding to accept it. The patient shall insist upon explanations until adequately informed and consult with all relevant persons before reaching the decision.

2.4.4 The patient and family shall accept all the consequences of his/her own, informed decisions.

2.4.5 The patient and family shall establish a good relationship with the health care provider and follow the treatment determined by the health professional primarily responsible for the patient's care.

3.0 The patient and family shall inform the health professional if he/she is currently consulting with or under the care of another health professional, including traditional medical practitioners related to the same, or another, complaint.

3.1 The patient and family shall keep appointments.

3.1.1 Every individual has a responsibility to maintain his or her own health and that of society by refraining from indulging in:
- Consumption of unhealthy food
- Substance abuse
- Life styles that have an adverse impact on health such as sexual promiscuity, reckless activities and physical inactivity

3.2 Every individual has a responsibility to accept all preventive measures sanctioned by law.

3.4 The patient and family must be aware of the limits of health care providers.

3.5 The patient should not expect a prescription at every visit, many illnesses are short-term and do not require medication; remember one does not need a pill for every sickness.

3.6 Take medicines exactly as instructed and complete any course of treatment.

3.7 Do not share prescribed medicines.

3.8 The patient shall conduct himself/herself so as not to interfere with the well-being or rights of other patients or providers of health care.

1.0 Services

4.1 Admission and stay in the hospital

In the event of an accident, illness or emergency, the patient will be attended to by competent health workers. The patient will be assessed and dealt with appropriately and immediately upon arrival.

Whether he/she is admitted as an emergency case or not, hospital staff shall:

- Inform the patient’s relatives/next of kin or whoever he/she wish, where practicable.
- Keep his/her clothes and valuables in a safe and clean place.
- Encourage the patient to give clear information about his/her illness and condition and the treatment plan for recovery.
- Encourage the patient to give clear information about domestic arrangements and any other information relevant to his/her stay in the hospital.

4.2 Outpatients Services

Provided the patient has followed the referral chain and does not require complex diagnostic procedures, he/she will receive treatment promptly.

- The patient has the right to clear information about his/her full treatment. Health workers will be happy to answer any concerns.
- The patient has the right to request for assistance or help when he/she requires it.

4.2 Inter-Hospital Transfers

In some cases, it will be necessary for the patient to be transferred to another hospital for continuation of treatment. If this is so, staff will:
• Give the patient’s information concerning the reason for the transfer and the arrangements to affect it.
• Inform his/her relatives or whoever he/she wishes of the transfer where such communication is possible.
• Upon discharge, if need be, the relatives will be advised to take the patient home.

4.3 Community Services

Healthy services are based on the referral chain. This means that the patient is required to visit his/her local health center on general practitioner in the first instance when he/she is not feeling well. However, if he/she is involved in an accident or emergency, he/she can go to the nearest hospital without referral.

• Village Community Worker (formerly known as village health workers (VCW)
• Environmental Health Technicians (EHTS)
• Field orderlies
• Community Based Distributors (CBDS) (Family Planning)
• Community Nurses
• T.B. Coordinators
• Health Centre Nurses

In the community, the patient has a right to:

• Communicate with health workers on matters which concern his/her health. He/she do not have to wait till he/she is ill.
• Continuing care at home, where there is need (e.g. invalidity, old age, recuperation, etc.). When the patient is discharged, the hospital will arrange for continuing care with the nearest health facility if necessary. In the event that the patient requests an ambulance, it will be dispatched as soon as possible. However, arrival time will depend on distance, condition of the roads and availability of ambulances.

4.4 Free Services in Country

The following services are offered free of charge:

• Immunization for children
• Immunization for pregnant women
• Treatment for mental illness

Sanctioning harmful traditional practices handout
The rights of people and societies to self-expression, including exercising their identity through traditional systems and beliefs are recognized and protected in the major international instruments. Traditional belief systems play critical roles in promoting social cohesion and providing support. However, some traditional beliefs and practices are recognized as infringing upon the right to health. States and community leaders alike are obliged to take action to eliminate these harmful traditional practices. Some of the traditional practices found to be harmful to the health of women and children are:
Early Marriages
• Forced Marriage
• Wife Inheritance
• Forbidding women and children from eating certain nutritious foods (buka)
• Drinking African Pitocin for the opening of the birth canal (e.g. Drinking elephant dung)
• Concealment of pregnancy during the first three months
• Traditional remedies for sunken fontanel (Nhova)
• Stopping breastfeeding an infant if one falls pregnant during the breastfeeding period (Kuyamwira)
• Use of traditional birth attendants: Let there be a drift of TBAs duties from actual supporting home deliveries to referring pregnant women to nearest health facility for ANC services.
• NB: ask community leaders to discuss harmful traditional practices common in their areas.

Ensuring safe use of traditional medicines
Evidence on the use of traditional and complementary medicines in the sub-Saharan African region suggests that up to 80% of people in some countries use the traditional health system and traditional medicines for primary healthcare. A number of traditional medicines have been proven potent and effective for treating specific conditions. For instance, herbal medicines that could combat malaria, skin condition and nutritional deficiencies have been developed for pharmaceutical use from traditional sources. However, many claims about the curative properties of traditional medicines are unproven. Their promotion may result in unnecessary and fatal delays to care-seeking by their adherents. The Africa Health Strategy of the African Union encourages governments, traditional health practitioners and communities to collaborate on analyzing existing systems, identifying best practices and strengthening interventions which show promise of effectiveness.

Other Social Barriers:
• Belief in faith healing
• Long distances to the health facility
• User Fees - most public institutions especially council owned health facilities have introduced user fees in an effort to raise finances to improve health service delivery
• Lack of mother’s waiting shelter
• Limited public transport infrastructure
Gender Inequality, Stigma and Discrimination

Goal
The aim of this module is to help participants make the link between their actions and attitudes and the negative health effects of stigma, gender inequity, and social marginalization.

Key competencies
By the end of this session, participants will:

- Analyze how social inequality and marginalization contribute to poor health outcomes in their communities
- Analyze how harmful gender values may compromise women’s and men’s health in their communities
- Discuss men’s roles in health and fatherhood
- Identify the root causes of stigma
- Explore how gender dynamics, stigma and discrimination combine to result in poor health outcomes for vulnerable groups

Materials Needed
Module II participant handout package
Flip chart paper (15 to 20)
Scissors
Index cards (2 per participant)
A4 papers
Sticky tack
Markers in different colors
Stigma picture booklet printed out either in color or black/white

4 signs in A4 size with the words ‘strongly agree’, ‘agree’, disagree’ and ‘strongly disagree’ written on them

Preparations
Develop lesson plan with activities, roles and responsibilities
Develop time-keepers schedule, with activities timed in minutes
Flipchart papers with major definitions written in Shona

Preparation time
One hour to develop the lesson plans
One hour for group preparation
One hour to practice the role play

Duration
3 hours and 15 minutes

Outline
Section I: Health inequalities and health inequity
Section II: Gender and Health
Section III: Stigma and Discrimination
Facilitator Notes

This module strives to address some of the underlying factors that prevent women from starting and adhering to medical recommendations. Some of the major issues that women cite as barriers to utilizing and remaining in care include:

- **Lack of participation in household decision-making.** Women often have to defer to their partners for all decisions, including health care for themselves and their children. In addition, women’s autonomy may be limited by the influence of the extended family, including mothers-in-law and sisters-in-law. Particularly in places where critical postnatal and neonatal care is aligned with traditional values and transferred from generation to generation, this may limit adherence to breastfeeding, infant and young child, and neonatal care recommendations.

- **Lack of financial autonomy.** The cost of care seeking (user fees, transportation costs) are all acknowledged as major barriers to women’s utilization of critical ANC, delivery and postnatal services. However, even in households that may have some discretionary income, women may not have a say in financial decisions. This may limit their ability to attend the necessary ANC services, prepare adequately for facility delivery and health emergencies, deliver at the facility level or return for postnatal care.

- **Limited spousal support during pregnancy and breastfeeding.** Cultural and gender values often associate pregnancy and child rearing with women’s roles. For this reason, men may be structurally separated from their partner’s experience during pregnancy and breastfeeding. As such, women may not receive the necessary emotional support during pregnancy and breastfeeding.

- **Denial.** Women who are newly diagnosed with HIV may have a difficult time accepting that they are HIV positive or may not accept the seriousness of their situation.

- **Self-stigma.** Women living with HIV may fear that if they are known to be HIV positive, they will be rejected by their family or their communities. As such, they may not divulge HIV status to their partners or families, or seek the care and support they need.

- **Male care giving may be associated with weakness of powerlessness.** Cultural and gender scripts associate care giving with female identity, and hold the view that men are not ‘naturally equipped’ for caregiving. As such, men may not see the need for being associated with health decisions.

- **Fear of violence or physical harm.** Women who are diagnosed with HIV may fear being physically harmed if they disclose their HIV status to their partner.

- **Social isolation after HIV diagnosis.** Women who are newly diagnosed with HIV may not have anyone to confide in, and may not immediately have anyone to share experiences and
information with. This may result in poor self- and infant care. It may also result in women feeling incapable of adhering to clinical recommendations

- **Fear of abandonment.** Women who are diagnosed with HIV may fear abandonment if they disclose their HIV status to their partner, and may abandon important care either immediately after diagnosis, or during the postnatal period, when the intensity of care is expected to diminish.

- **Limited couples’ communication on sexual health.** Couples’ communication on sexual and reproductive health may be poorly modeled or frowned upon. This might limit women’s ability to access critical fertility services. As a result, women may be unable to optimally space and time their pregnancies.

- **Resistance to condom use in marriage.** Condom use in marriage might be viewed as an indication of infidelity. For this reason, both women and men might not discuss condom use with their marital partners, and sexual risk taking might continue throughout pregnancy and the breastfeeding period.

- **Men having multiple concurrent sexual partners.**

- **Lack of sexual negotiation power.** Cultural and gender values may make it impossible for women to refuse sexual intercourse with their partners, or negotiate the terms and timing. As such, women may continue to be placed at risk, even when partners are known to be HIV positive or at risk for infection.

- **Pressure to bear children.** Various cultural and gender scripts support early and continuous child bearing, including an expectation of child bearing as soon as one year after marriage, preference for a son – even after numerous female children, pressure to repeat pregnancies – even after a clear history of obstetric problems, and preference for large families. These expectations may be tied to the perception that femininity is tied to fertility. Women may also fear being labeled as ineffective wives and abandoned in the case of any childbearing delays.

- **Preference for closely spaced children.** In some cultural contexts, women desire closely spaced children under the perception that economic resources could be better managed (e.g. child necessities could be handed over from child to child. Women may also perceive that having all their children ‘at a go’ will make child rearing easier (i.e. avoid ‘stretching out’ the years spent raising children in infancy. Finally, women may perceive that having children spaced too far apart will result in children being ‘lonely’. Women may deliberately space children closely, thereby increasing their obstetric risk.

**National Statistics**

These issues and others result in poorer HIV outcomes for women relative to men and poorer health
outcomes overall for women and children. According to the last Country DHS (2010/11), despite the fact that more women (52%) have comprehensive knowledge of HIV and AIDS than men (47%).

- HIV prevalence among women stands at 18% and men at 12% across the population.
- The average prevalence rate for 15 to 24 year olds is 5.5% (2011). However, female youth are at double the risk (7.8% prevalence) as compared to their male peers (3.6%).

Also according to the ZDHS 2010/11 and other sources:

- Young men are much more likely than young women to report having multiple sexual partners in the 12 months preceding the survey (8 % and 1 %, respectively).
- Among young people who had ever been married, only 2 % of young women reported having had sexual intercourse with more than one partner in the previous 12 months, compared with 24 % of young men.
- Maternal mortality rates stood at 960 per 100,000 live births in 2010/2011. This represented a deterioration from estimated maternal mortality rates, which was in
- HIV contributes to an estimated 26% of all maternal deaths and 20% of all infant deaths
- Among women in the reproductive ages, 32% of all pregnancies were unplanned/unintended
- 3 in 10 women >15 years of age have suffered some form of physical violence

**Using key resource persons**

Where possible, it would be helpful to invite the members of the district gender committee or the health promotions unit to reinforce the content of this module. District officials will be more familiar with the local dynamics. They may also know the individual participants. In addition, district officials will be comfortable with the Ministry-sanctioned messages. Their participation is importance to ensure alignment with the priorities and direction of the Ministry.

**Handling gender issues with sensitivity**

It is critical for the facilitator to be aware of the sensitivity surrounding of many of the issues that will be discussed with the participants. Many of the participants themselves might have staunchly gender inequitable beliefs. The following tips may help the facilitator ensure that the discussions on gender do not spiral into confrontation:

- Thoroughly research the credibility of any key resource persons that you may want to invite. Ensure that there is no history of confrontation or rejection by the community.
- Use your key resource person. From time to time, give the floor to the key resource person.
- Find the ally in room. Very often, men or women in the room have been made aware of
gender issues and may have viewpoints that are closer to the goals and objectives of EGPAF. Draw upon this person’s views and insights from time to time.

- Link gender and stigma with health. When introducing the module, make the participants aware that the reason why gender is so important is that there is a clear link between gender and health. This includes differences in risk-taking, care-seeking, and decision-making.

- Reinforce how gender, stigma and discrimination all work together to jeopardize family health.

- Forewarn the participants. After introducing the module, inform participants that you will be dealing with issues that might become sensitive.

**Part I: Facilitate the ice-breaker – Dudu Mduri!**

As the group chants the ‘Dudu Mduri!’ refrain, the facilitator calls out a name of one of the participants in the group at random. The nominated person will have to say whatever comes to mind when they hear the words ‘gender’ or ‘stigma’. After their turn is over, each person will in turn nominate someone in the group at random to say what they think. The song will continue until all the participants have said at least something.

**Part II: Introducing the module on gender inequality, stigma and discrimination**

Introduce this module by explaining that while the Ministry of Health recognizes the right to health and is investing to ensure that everyone can realize this right, there are some groups that are prevented from realizing their full rights to health by different structural barriers.

Explain that some of the most significant structural barriers include gender inequity, stigma and discrimination. These three forces act to prevent people from accessing services in a timely manner, and by suppressing their ability to freely choose life-saving services when and as needed.

Finally, explain that they endanger more lives when they are present and acting together. Explain that we will discuss these issues, how they affect women and children in particular, and what roles community leaders could play in addressing them.

**Section One Health Inequalities**

**Part III: Discuss the definition of health inequality and inequity**

Explain that it is impossible for everyone to have the same levels of health. For instance, certain conditions may be inherited from parents. Life events such as pregnancy may temporarily or permanently affect health. Biology may also determine certain risks – for instance, a female cannot be at risk for prostate cancer. Lifestyle, including stress, diet and activity/exercise can trigger conditions like hypertension, depression, or heart conditions. Finally, random events such as accidents could expose individuals to different levels of risk. All of these factors mean that one person’s health issues will not be the same as another’s. We can say that some level of health inequality occurs naturally.
However, some groups may generally have higher levels of exposure to disease agents, illness or death compared to other groups. These groups that are more affected may be said to be vulnerable. When this occurs, and there are no efforts to address the risk levels of those who are affected, we can say there is health inequity.

Explain that it is important to make this distinction because while there will always be accidents, sickness and death, but efforts should be made to address imbalances that can be controlled. Explain that a good case in point is the government’s effort to make sure that no children die from HIV and AIDS. The data shows that all children are at special risk during their first few days of life. However, data also shows much higher deaths among children exposed to HIV during delivery and breastfeeding than others. Recognizing this, the government is placing priority on reducing new HIV infections among infants to almost zero.

Likewise, the government is placing priority on addressing gender inequality, stigma, and discrimination, because the groups that suffer from these negative factors are more likely to have poor health outcomes.

Part IV: Facilitate the group discussion on health inequality and inequities in our communities

Next, explain to participants that we will discuss real life examples of why these concepts are important and how they might be costing lives in their communities.

Ask participants to gather in groups of two to four, preferably with people who are from the same local area or community. Ask participants to spend a few minutes discussing the groups in their communities who tend to have worse health, worse access to health services, or cannot afford the health services they need.

Explain that this does not need to be about any specific health issue. Ask them to discuss who these groups are, what the connections across these groups are, what factors contribute to their situation, and what participants feel about this.

Invite participants to report back on their discussions. Discuss any factions that are consistently mentioned by the different groups. Discuss patterns and conclusions that contribute to health inequity across different communities. If participants do not mention them, inquire about the following groups - ask whether they exist and why their health might be considered to be worse off than others:

- Orphan
- Women living with HIV
- HIV exposed children
- Migrant workers
- Long distance truck drivers
- Commercial sex workers

Encourage participants to discuss and reflect on what can be done about the needs of these groups.
Section Two: Gender and Health

Part V: Introduce the section on gender and health

Inform participants that we are concerned about how men and women differ in their health and in their engagement with health services. Explain that there is increasing attention brought to the fact that the way we raise men and women influences their behaviors, which in turn influences wellbeing.

As an example, share the observation that men are raised to be strong and to avoid any displays of weakness. As a result, they may not pay attention to important signs of illness until it is too late. Similarly, women are raised to be pious and stoic; they may not have an acknowledged identity if they are not married. For these reasons, women may not want to admit when a marital relationship is endangering their lives (as in the case of gender based violence) or that of their children (as in the case of incest). As another case in point, a woman might keep having children close to each other even at great risk to her health because they are all female, and without a male heir she is not valued as a wife or mother. Ask participants to reflect on these issues, and share other examples in which the notion of maleness is exaggerated to men’s disadvantage, or the notion of femaleness is exaggerated to women’s disadvantage.

Start the discussion more broadly, and then start to hone in on some of the gender values and attitudes, and their implications for health.

Explain that gender can be defined as the range of physical, mental, and behavioral traits specific to and defining of the difference between male and female. Explain that the differences between men and women often have very deep cultural and traditional roots. They are influenced by the values of the culture.

Next, explain that values are derived not only from culture, but from other influences. For instance, in modern day (Country), religion, politics and technology are becoming powerful forces that are shaping broader values. As (Country) becomes more developed and as the times change, the culture will have to change with the times. The important key is for a culture to shed the issues that make it impossible to adapt successfully to the forces of modernity and time, without losing the core identity that defines our heritage. However, explain that values change as the times change.

Part VI: Facilitate the gender values clarification exercise

Hand out four different colored index cards to each participant (on which should be written one of the words ‘strongly agree’, ‘agree’, ‘disagree’ and ‘strongly disagree’) before the activity begins. Choose a few statements from the list below that you think will lead to the most discussion. Warm up the group with some of the more general statements before honing in on the statements most closely related to the health issues of interest.
Explain that this activity will give participants a general understanding of their own and of each other’s values and attitudes about some important gender issues. Remind the participants that we all have the right to our own opinions. Ensure that participants keep the dialogue civil and refrain from name calling or finger pointing.

Read the first statement aloud. Ask participants to raise the colored index card that says what they think about each statement. As they do this, allow people to explain their feelings about the statement. Make sure the participants who have different views have the opportunity to voice them. Probe for issues such as:

- Which statements did you have strong opinions about?
- Which statements did you not have very strong opinions about?
- Why do you think this is so?
- If your opinion differed from other participants’, how did it feel to discuss this?
- How do you think most people in this community would respond to this statement? The men? The women?
- How do you think people’s attitudes to the statements might affect the way that they deal with their male and female colleagues?
- How do you think people’s attitudes to these statements help or do not help to reduce health inequities and the spread of HIV and AIDS?
- Do you encounter such issues in this community? What are the implications?

The statements marked with * (asterisk) have been good for starting discussion in the past.

<table>
<thead>
<tr>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is easier to be a man than a woman. *</td>
</tr>
<tr>
<td>Women make better parents than men. *</td>
</tr>
<tr>
<td>A woman is more of a woman once she has had children.</td>
</tr>
<tr>
<td>Sex is more important to men than to women. *</td>
</tr>
<tr>
<td>A man is entitled to sex with his partner if they are in a long-term relationship. *</td>
</tr>
<tr>
<td>Men are naturally more violent than women.</td>
</tr>
<tr>
<td>If a difficult or important decision has to be made in a family, the man should make the final decision.</td>
</tr>
<tr>
<td>Domestic violence is a private matter between the couple.</td>
</tr>
<tr>
<td>Women want to be beaten, so they deliberately provoke their partners</td>
</tr>
<tr>
<td>If women really didn’t like the violence, they would leave an abusive relationship.</td>
</tr>
</tbody>
</table>
- Men who live and work away from home should have other girlfriends.
- Women who live and work away from home should have other boyfriends.
- It is better to have a son than a daughter.
- Men are more productive than women and therefore should be the breadwinners.
- A man who is not the clear breadwinner in his home is a failure.

Let participants reflect back to earlier statements if needed. Allow each discussion to come to its end naturally. After a few participants have talked about their attitudes, ask if anyone wants to share any insights they gained during the discussion.

**Part VII: Facilitate the discussion on the links between gender and health**

Highlight the fact that many gender attitudes make it impossible for couples to work together as a true team. Also discuss the fact that many gender values prohibit people from taking important steps to safeguard their health and the health of their families. Discuss that this has important implications for communities and for society as a whole.

Share some of the statistics on the gendered dimensions of health (some of these are summarized in the facilitator notes). Highlight some of the issues around:

- **Gender and care-seeking behaviors.** Highlight that men are much less likely to seek healthcare for ailments than women are, even when the signs and symptoms are glaring. Sometimes, men hide their conditions from their partners. Explore the gender values and attitudes that drive this behavior, including the belief that men should be strong and that men who contract any conditions are bringing sickness to the home. *Encourage participants to discuss how this affects families in their communities.*

- **Gender and risky sex.** Highlight that men are much more likely to pay money or exchange favors for sex. Explain that even though increasing numbers of men are using condoms with casual partners, they are less likely to use condoms consistently with long-term partners, even if both people are also having sex with other people. Explain that women are also made vulnerable by risky sex for different reasons – without viable means of livelihood, women may indulge in risky sex in order to meet their basic needs. Sometimes, vulnerable families may marry their daughters off early (to sometimes older men) in order to reduce household costs. *Encourage participants to discuss instances of this that they may have witnessed in their communities.*

- **Gender and multiple concurrent sexual partners.** Highlight the reasons why men are much more likely to have more than one sexual partner at a time (up to 8 times more in *(Country)*). Remind participants that research has shown that having multiple partners at the same time speeds the spread of STIs and HIV – when large numbers of people in a community are in relationships with
more than one person, they contribute to the formation of sexual networks that connect people through overlapping sexual partners and act as efficient pathways for the transmission of HIV. This may explain the high rates of HIV in the most affected communities and groups. Explore the attitudes that encourage this (including the belief that variety in sexual partners is seen as essential to men’s nature as men, and that men will inevitably seek multiple partners for sexual release). Encourage participants to discuss how they have seen this play out in their communities.

- **Gender and HIV infection.** Explain that often, existing gender-related norms condone men’s violence against women, grant men the power to initiate and dictate the terms of sex, make it extremely difficult for women to protect themselves from either HIV or violence, and discourage men from accessing vital health care services. For instance, HIV negative married women who are aware of their partners’ HIV positive status may be unable to refuse sex with their partner, or even negotiate condom use for their protection. Encourage the community leaders to discuss how this might be affecting their communities.

- **Gender and HIV testing.** HIV testing and counseling (HTC) services provide an entry point to HIV prevention programs, treatment, as well as an opportunity to access medications that can prevent the child from getting HIV. However, both men and women experience gender-related barriers to these services. Women are often reluctant to participate in these programs for fear of disclosure and abuse from their male partners should they test HIV positive. Women’s fears of violence upon disclosure are not empty. Numerous women have experienced violence or marital/relationship break-up following disclosure. Other common barriers to women’s disclosure are: fear of being abandoned (closely tied to fear of losing financial support from their partners); fear of rejection/discrimination; fear of upsetting family members; and fear of being accused of infidelity. Many of these relate to their male husbands or partners.

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**Section Three: Stigma and Discrimination**

**Part VIII: Facilitate the activity ‘Naming stigma through images’**

Display the selection of general stigma pictures on the wall, the floor, a washing line, etc. Divide the participants into groups of two or three. Ask each group to walk around and look at as many pictures as possible.

Ask each group to select one of the pictures and discuss:

- What do you think is happening in the picture in relation to stigma?
- Why do you think it is happening?
- Are any of these images familiar? Does this happen in our own community? At which level: individual, family, community, institutional (i.e. health facility, schools, churches, etc.) does this occur? If so, discuss some examples.
- What can community leaders do to encourage change in behavior and attitudes in their communities?
Ask each group to present their analysis. Record the key points on flipchart sheets, and then read through the main points from the flipchart.

Ask the whole group to reflect on the key points, “What do we learn from this exercise?”

**Part IX: Introduce the discussion on stigma and discrimination (15 minutes)**

Open this section by stating that we all know what stigma is. We stigmatize when we say things like “she was promiscuous” or “he deserves it”. We also stigmatize when we do things such as isolating people when they get sick and excluding them from decision-making.

Ask participants how they personally describe stigma. After taking a few responses, sum them all up by stating that to stigmatize is to label someone; to see them as inferior because of an attribute they have.

Describe that stigma is a process that points out or labels differences (e.g. stating or thinking that “He is different from us – he coughs a lot”). It links differences between people to negative or undesirable behavior (e.g. stating or thinking that “His sickness is caused by his sinful and promiscuous behavior”). Finally, it separates ‘us’ and ‘them’ through shunning, isolation, and rejection. It creates or reinforces loss of status and discrimination (loss of respect, isolation).

Ask participants what the main causes of stigma in the cases they have seen are. Fill in the gaps. The responses should include:

- Insufficient knowledge, misbeliefs, and fears about HIV transmission
- Moral judgments about people
- Fears about death and disease
- Lack of recognition of stigmatizing actions

Point out that the previous exercise displayed various types of stigma that can occur in communities and ask participants to name these. They include:

- **Self-stigma**: when people experience self-hatred, shame or blame or when they isolate themselves from their families and communities because they feel they are being judged by others so. PLHIVs go through this, especially immediately after diagnosis.
- **Felt stigma**: where people have negative, harsh or judgmental perceptions or feelings towards specific groups such as PLHIV.
- **Discrimination**: where people put their negative feelings, thoughts and attitudes into action.

Through this discussion, participants may have already started describing the actions through which stigma occur, including:

- Physical and social isolation from family, friends and community
- Gossiping, name-calling, violence and condemnation
• Loss of rights and decision-making power
• Self-blame and self-isolation
• Families, friends, and associates being affected by the stigma
• Judging people and assuming things about them based on their looks, appearance, type of occupation, or lifestyle

Through these discussions, participants may have noted some of the issues that occur in their communities, such as:
• People living with HIV being chased from their family, house, work, rented accommodation, organization, etc.
• People avoiding certain services in the health facility out of fear of being associated with HIV or labeled as HIV positive
• Prohibiting family members from using certain services because of fear of being labeled as HIV positive
• Dropping out of school (resulting from peer pressure – insults)
• Depression, suicide, alcoholism.

Explain that these are all effects of stigma, and that they have tremendous consequences for communities.

Part X: Facilitate the drama skit - Stigmatizing Acts

Tell participants that next, the facilitation team will present a brief drama skit. Act out the skit according to the guidance below (a more appropriate skit could be developed based on the needs of the community).

A brother is visiting his sister. He has been busy and hasn’t seen her in a while. She looks bothered, so he inquires what seems to be bothering her. After much hesitation, she finally tells him that she was tested for HIV and diagnosed as HIV positive. He repeatedly asks whether she is sure and insists on seeing some documentation.

While he is reading the documents, she announces that she has been a bad guest. She leaves the room and returns with a tray of refreshments, including a glass of water.

The brother asks whether his sister has washed the glass and utensils. He examines each carefully and asks her to rewash a few. Once or twice, he mutters to himself: ‘we just need to be careful.’

Finally, he says he is okay and does not need anything. He leaves hurriedly, saying that he may not be able to return and will send his wife to deal with ‘the matter.’

The sister is left looking saddened and slightly depressed.

THE END.
Ask the community leaders to reflect on what they think the message of the drama skit is. After a few responses, ask them to share why they think people stigmatize. If responses are not naturally forthcoming, probe by asking them to reflect on cases they have witnessed or heard of in their communities. Ask them to reflect on what the stigmatizing character in the drama skit is likely to be thinking throughout this entire encounter. Explore the more active ways people may stigmatize (such as gossiping, isolation, rejection, etc.) as well as some of the unconscious ways people stigmatize – in their actions, words and reactions. Explore some ways that the participants themselves might have stigmatized others in the past, by judging, calling people names, etc.

Ask community leaders to discuss the effects of stigma and discrimination at community level and how they hinder progress on community health. Ask them to share some of the ways that they could contribute to addressing stigma and discrimination.

**Part XI: Recap the module**

Ask the participants to share the useful highlights of the discussions that they have had and to envision using them in their roles as community leaders.

Link the content of this module to some of the key concepts: our daily words and actions have a profound influence on our health; men and women have different risk profiles with different implications; we can stop gender inequity and stigma from preventing use of health services by the most vulnerable groups. Explain that in the next module, we will explore the critical health issues that are influenced and determined by these social barriers.
Sexual Health, Maternal and Child Health, and Achieving EMTCT

Goal
The aim of this module is to familiarize participants with basic information on sexual and reproductive health, maternal and child health, and EMTCT. The module also emphasizes the links between rights and the various health issues.

Key Competencies
By the end of this session, participants will:
- Highlight the implications of delayed care seeking for men’s and women’s health
- Discuss the maternal morbidity and mortality burden of disease from maternal morbidity
- Review the direct and indirect causes of maternal mortality and link these to community and household practices
- Discuss men’s roles in health and fatherhood

Materials Needed
Module III participant handout package
Flip chart paper (15 to 20)
Scissors
Index cards (2 per participant)
A4 papers
Sticky tack
Markers in different colors

Preparations
Develop lesson plan with activities, roles and responsibilities
Develop time-keepers schedule, with activities timed in minutes
Flipchart papers with major definitions and key information/statistics written in Shona

Preparation time
1 hour to develop the lesson plan
1 hour for group preparation
1 hour to practice the role play

Duration
4 hours 30 mins

Outline
Section I: Basics of Sexual and Reproductive Health
Section II: Basic issues in Maternal, Neonatal and Child Health
Section III: Maternal mortality and the three delays
Section IV: The four pillars of preventing pediatric HIV
**FACILITATOR NOTES**

What are some of the common beliefs, perceptions, and practices surrounding pregnancy, birth, and breastfeeding commonly encountered in the communities?

**Preconception**

**Myth:** Vasectomy predisposes men to prostate cancer.

**Practice:** Women use herbs to increase sexual satisfaction.

**Implications:** Some of these may be irritating/corrosive and erode the cervix, predisposing women to cancer.

**During pregnancy**

**Myth:** Sex during pregnancy ‘feeds the fetus’ and is necessary for normal fetal development.

**Practice:** Pregnant women eat soil (esp. soil from termite tubes and anthills) because they think it is nutritious (and to address iron deficiency).

**Practice:** Women are sent away to their parents’ (or in-laws) homes for care when they are close to delivery. In and of itself, this may not predispose to harm, but the continuity of care is disrupted.

**During labor and delivery**

**Practice:** Women may be given ‘African Pitocin’ (extract of elephant dung) to speed the labor process/promote dilation.

**Implications:** This may actually place women at greater risk. Strong rapid contractions may put women at risk for bleeding.

**Immediately after delivery (postpartum)**

**Perception:** Condom use is not widely accepted especially for those married.

**Implications:** We need to emphasize that especially for those couples that are pregnant or lactating, this protects the child.

**Practice:** Sex during postnatal period can prevent the child being deaf – ‘opening the child’s ears.’

**Practice:** When women deliver in the cultural setting, the practice is to remove the baby immediately after birth so that the mother can ‘rest’, which interferes with mother-baby bonding and with EBF.

**Myth:** Watery milk that comes out first when the baby has not fed for a few hours is bad milk hence should be expressed and thrown away hence its should not be given to the baby.
Question: Is it possible for a baby not to have a suckling reflex?

Implication: Poor sucking may be indicative of poor survival instincts in an infant.

Question: How to engage men in realizing the dangers of having early sex and give the woman time to recuperate after she has delivered. Highlight the fact that the postnatal period presents an opportunity for the male partner to be circumcised around the time of birth – wound healing for a pregnant woman and a circumcised man are approximately the same.

**Recognizing potential danger signs of child illness**

Myth: Babies cry because they are hungry (not because they are experiencing some kind of discomfort).

Question: Why do babies sometimes have a tight/tense stomach?

Answer: This is a sign that something is not right. Look out for this with children who are receiving mixed feeding.

Myth: Superstition that if you buy yellow clothing, the baby will turn yellow.

Answer: Yellowing is a sign that the baby has jaundice. Jaundice is a clinic condition that is not caused by yellow clothing.

**For ensuring the neonate’s health (preventive)**

Practice: Use cow dung or salt and water traditionally to apply to the child’s stump.

**For curing neonatal conditions (treatment)**

Practice: Use administer a salt rub to cure the conditions associated with a sunken or bulging fontanel.

Implications: This practice recognizes that the condition of the fontanel might be indicative of child health, but does not differentiate between sunken fontanel (dehydration) and bulging fontanel (meningitis). As a result, if a child is dehydrated, they are given more salt, and placed in additional danger. Also, a child with a critical condition such as meningitis may not receive timely care for his/her condition

Practice: Culturally, it is understood that children with jaundice should be put in the sun to cure.

Practice: The use of breast milk to clean a baby’s eyes if they are discharging.

Implications: If the mother has HIV, the child might be exposed.

Advice: The recommendation is to utilize weakly salted water.

**Infant and young child feeding**

Myth: Colostrum (first milk) is expressed and wasted because it is considered to be spoilt milk
Advice: Colostrum has a slightly different color from mature milk because it has a rich mixture of proteins, vitamins (such as vitamin A), growth factors, enzymes and anti-infective agents. All of these help the newborn through the first three to four days of life. Although it is small in quantity, as newborns have a small digestive system, it is packed with nutrients and antibodies that help give newborns more resistance to infections. Colostrum also has some factors that help newborn babies get rid of the meconium (black sticky poo) from their gut after birth.

Myth: If you have travelled for a day or you weren’t able to breastfeed for a day, you can’t breastfeed the child because the milk is ‘rotten’.

Advice: Women should actually express milk while they are away to promote continued lactation (the breast milk that is secreted when a mother has been away is not water or spoilt milk).

Question: What is the role of men in making sure that the baby receives EBF?

Answer: Ensure the mother is hydrated, psychologically stable (not depressed or stressed), physically prepared to breastfeed, nutritiously fed, attended to in the case of breast conditions.

Question: Why is formula feeding not good if Nan is the same consistency as breast milk?

Answer: Breast milk contains factors that formula milk does not have, including protective factors from the mother’s blood that boost the baby’s ability to fight infections.

Question: At 6 months onwards, doesn’t introduction of complementary feeding increase the risk of HIV?

Answer: Early weaning should not take place earlier than 12 mos. Weaning should occur gradually, no shorter than 1 month.

Question: If exclusive breastfeeding is fine, and exclusive formula feeding is fine, why is mixed feeding bad?

Answer: There are various reasons why mixed feeding is not the optimal solution for a baby, especially babies less than 6 months. It is important to consider that the baby will not get the highest level of protection possible. Also, the more formula feeding your baby has, the less breast milk you will produce over time.

Part I: What has changed?   (15 minutes)

Ask for two to three participants from the room. Ask the participants to observe the room and its participants very closely, and memorize what they see. Then ask the pair to turn their backs to the rooms. Now, announce that while the pair has their backs turned, everyone must make changes to the set-up of the room. For example, the door should be opened, the blinds should be drawn, people
should trade seats, bottles of water should be removed from tables, flip charts should be switched around, etc. The changes should be made as quietly as possible and without speaking, so that the principals have as few clues as possible on the changes being made. Give about three minutes for these changes to be made. Now ask the pair to turn back and face the room. They should try to guess as many of the changes as possible in one minute or less.

**Part II: Introduce the module (15 minutes)**

Ask participants to reflect on the most recent death of a young woman they have witnessed or heard of. Explain that this woman should be between the ages of 25 and 49, but should not have died from an accident, surgical complication, murder or suicide. Ask participants to recount the story and to list the main reasons why this death occurred. Select a few of the participants to share the cases that they immediately thought of.

A significant number of the deaths mentioned will probably be due to complications during labor and delivery and in the postnatal period. Focus on the deaths that are due to pregnancy and explore issues such as: where the death took place, who was providing care at the time of death, the major barriers to effective care, the early warning signs that were missed, the time it took to get care and any other factors that contributed to the death.

Explain that the trends for deaths during pregnancy, labor and breastfeeding are not improving in many communities across (Country). In the 1990s, deaths among pregnant and postnatal women increased from 720 to 960 deaths per 100,000 women. These deaths are largely preventable. A range of factors increase the risk of death for pregnant women, including poor reproductive health choices, lack of awareness, poor compliance with clinical recommendations and poor response to the critical danger signs during this period. The economic costs for families and communities are high – families often have to spend tremendous amounts. The deaths and disability due to all these factors can be easily managed or prevented.

Everyone from community leaders to community members has a role to play in addressing this, as highlighted and discussed in the last module (remind participants of the discussion on the obligations and duties of individuals and communities). We will examine these in depth in this module and also discuss the critical points at which family members, community members and community leaders could intervene to save mothers’ lives.

**Part III: Discuss the importance and implications of reproductive health (45 minutes)**

Ask participants to share what they think of when reproductive health is mentioned and what the main reproductive health issues in their communities are. Probe for issues such as STIs, family planning, gender based violence, coercive sex and cancers of the reproductive system (cervical, uterine and prostate). Explain that while some reproductive health issues may be due to infections, others may not.
Explain that reproductive health issues are of concern because:

- Many pregnancy risks are associated with sexual health issues (some STIs can cause miscarriages and issues such as poor fetal development; uterine fibroids can affect fertility and the safety of the fetus).
- Child health can be affected by poor sexual health (children can be exposed to different types of STIs).
- Some STIs can lead to cancer in both men and women.
- Many maternal deaths can be associated with poor reproductive health (for instance, getting pregnant too young, too old, having too many children or having children too close together).

Next, ask participants to name the STIs they know and their signs and symptoms. These should include:

- Gonorrhea
- Syphilis
- Chlamydia
- Genital Herpes (Herpes Simplex Virus)
- Human Papillomavirus (HPV)

Explore participants’ understanding of:

- Whether STIs can be treated (Answer: Some can be, but not all.)
- What the signs and symptoms of STIs are (Answer: genital sores, difficulty passing urine, pain or itching or inflammation of the genitals)
- Whether STIs always show signs and symptoms (Answer: No. A significant number of cases are ‘silent’)
- Whether STIs can be passed to their children (Answer: Yes, if they are not treated)
- What the long term effects of STIs are (Answer: They include infertility, neurological damage)
- What the effects of STIs in pregnancy and for newborn children are (Answer: They can lead to problems with development, miscarriage, smaller weight at birth, blindness, etc.)

Discuss the fact that STIs diagnosis and treatment is only one priority for reproductive health. Another major issue that women face is the issue of child spacing. Ask participants to discuss:

- What they believe the best and healthiest child spacing patterns are
- Which beliefs and attitudes encourage poor child spacing
- What participants feel about couples’ access to contraceptives or health spacing and timing of births

Share the handouts on sexual and reproductive health.

Part IV: Facilitate the group role play on unsafe abortions (30 minutes)
Divide the participants into three groups. Each group will represent a different stakeholder group in the community (could be health workers, community leaders, religious leaders, teachers, parents, etc.). In addition, ask for one volunteer to play the central role in this skit. Take the volunteer aside, and provide the following bio-sketch, which will guide his/her actions throughout the skit. The volunteer will be playing the role of:

- A 14 year old girl who has just found out that she is pregnant.
- She knows who the father of the child is but is scared that she will be harmed if she discloses his identity.
- She has asked her friends for advice on what to do. Some told her to go to the health clinic; others, however, gave her information about an old woman in the village who can ‘take care’ of her pregnancy.

Ask the volunteer to act out his/her part for a few minutes. Next, ask the participants to act out a role play according to the group they represent, modeling what they believe a young girl in a similar situation would go through in their communities.

Ask participants to discuss the issues in their communities and their encounters with similar scenarios. The group should reflect on the following questions:

- How typical are such cases in our communities?
- What are the usual outcomes of such cases? Would most girls opt for unsafe abortions? Why?
- What are the usual responses and actions of the duty bearers regarding such cases? What happens in real life and under the usual circumstances?
- What actions could be taken by educational institutions, parents, community leaders to redress this crisis?

Explain that unsafe abortions are a leading cause of maternal mortality in (Country) and all over the world. Abortions are illegal in (Country), with very few exceptions. Even for these exceptions, the protocols for qualifying are quite extensive: the client needs two letters from licensed medical practitioners (doctors) attesting to the medical necessity. They must also receive approval from the high court. As a result, many women who undergo abortions may have received services from an unaccredited and untrained practitioners who could do grave bodily harm. Any woman who receives an abortion must receive clinical post-abortion care. Explain the links between unsafe abortions and women’s empowerment, GBV, coercive sex and poor access to family planning services. Ask the participants to share what they think can be done about unsafe abortions in their communities and what role they can play in reducing unsafe abortions. Make sure to address the most vulnerable groups and the goal to reduce the loss of life among the girls and women affected.

**Part V: Introduce the section on maternal health (45 minutes)**
Ask participants to share who in their communities they think are primarily responsible for maternal health and why. Ask specifically about the role of the partner, the extended family and the community.

Explain that one of the key measures of maternal health is the number of women who die during pregnancy or within 42 days of delivery. Explain in the same way, to assess child health, we track: the number of children who die within 28 days of birth, the number of children who die within 1 year of life, and the number of children who die before their fifth birthday. Keep these definitions on flipchart paper and place it in a prominent and central location so that the participants can reflect on these definitions.

Share the relevant data with the participants. Explain that there are many care and prevention practices that families and communities observe around the time of labor and in the postpartum/neonatal period. Ask participants to share these practices and the effects. Discuss these practices implications for the health and wellbeing of women, newborns and infants.

**Part VI: Facilitate a discussion on direct and indirect causes of maternal and child mortality**

Ask participants to share what they think the main causes of maternal deaths are. Recap these (they include: severe bleeding, prolonged and obstructed labor, infections after childbirth, high blood pressure, unsafe abortions, etc.). For each of these, link the key indirect causes (some of these include community level practices discussed earlier).

Explain that most child deaths occur during the first 28 days of life, when children are at their most vulnerable. Ask participants to share what they think the main causes of child deaths are. Recap these (they include: preterm birth, complications during delivery, pre-term complications, birth asphyxia (halted breathing at birth), infections (most commonly sepsis, meningitis and tetanus) and congenital defects). For each of these, link the key indirect causes (practices at community level).

**Part VII: Facilitate the discussion on home births (25 minutes)**

Ask participants to define what a home birth is. Emphasize that a home birth is any birth outside an accredited health facility. Ask participants to reflect on how common home births are, and the dangers associated with them. Ask participants to reflect on:

- How many deaths have been due to home births (or births outside the health facility) in their communities?
- How much do they believe delivering at home contributes to deaths in their communities?
- Are any specific women disadvantaged and affected?
- Why do these home births occur? What are the social issues? What are the barriers within the health sector?

**Part VIII: Discuss the three delays models (30 minutes)**
Explain to participants that the research indicates that most deaths occur because of a failure to get timely and appropriate care. These delays generally occur at three different levels:

- **At the household level:** For women and families, the decision to seek appropriate medical care for a childbirth or emergency is delayed. This is usually because the affected individuals:
  - Cannot afford the costs associated with user fees and seeking transportation
  - Seek alternative (traditional) care first
  - Fail to recognize the urgent need for medical attention
  - Lack information about the danger signs during labor and delivery
  - Lack authority within the family to make decisions (especially mothers)

- **At the household and community level:** Women and families do not get to the health facility on time. These delays are caused by:
  - Lack of adequate transportation infrastructure
  - Distance of the health facilities
  - Poor preparation for the birth or health emergencies.

- **At the facility level:** Women and families may get to the health facility but may not get appropriate care on time. These delays are caused by:
  - Staff shortages or lack of the required skills
  - Shortages of equipment or drugs
  - Lack of basic infrastructure such as water, electricity, or space

Ask participants to discuss their role in helping their communities find solutions to these barriers.

**Part IX: Facilitate Mazvita’s case study (30 minutes)**

Provide the handout with Mazvita’s case study to the participants. Have you or one of the participants read the case study.

Ask participants to indicate whether they have ever come across such a case or scenario. Pose the following discussion questions:

- Is this a common scenario in our communities?
- What are the factors that led to the deaths of Mazvita and her baby?
- What are the major violations of the right to health that we see in this case?
- What role did the community and family play in this case?
- Discuss issues such as:
  - The decision to deliver at home with a traditional birth attendant
  - The delay in identifying a serious health issue
  - The family’s financial preparedness for an emergency
  - The fact that her partner is never mentioned

Draw upon some of the local practices and diplomatically highlight how these might be critical barriers.
Part X: Discuss why the PMTCT program is an important component of maternal and child health

Explain the key services women receive from antenatal care through delivery, emphasizing PMTCT as part of the package. Refer to the participants’ handout package. Also explain the key child health interventions, emphasizing PMTCT as part of the package.

Highlight the fact that the Government of (Country) has committed to implementing programs and infrastructure to ensure that new infant HIV infections are reduced to almost zero. This is possible with the new drug combinations, and if pregnant and breastfeeding women are immediately placed on lifelong ART after being diagnosed. Emphasize that an important benefit of this regimen is that HIV’s contribution to maternal mortality can also be drastically reduced.

Highlight the services and assurances women can get from the health sector that they don’t get outside the health system.

Part XI: Recap the module

Ask participants to reflect on what they have learnt from each other during this session. Ask participants to reflect on what their role can be in redressing some of the poor health trends.

Explain that in the next module, we will start to explore the impact of these critical health issues at the community level.

Our Community’s Health Profile

Goal: This module aims to help the community leaders apply a social framework to understand the health issues in their communities

Key Competencies: By the end of this session, participants will:
- Understand the vital statistics (MNCH-related) from their health facilities and communities
- Explore major service delivery strengths
- Explore major service uptake gaps in their communities
- Examine the social, economic, and cultural factors influencing health outcomes for presented cases

Materials Needed: Module IV participant handout package
- Index cards (five different colors)
- Flip chart paper (15 to 20)
- Markers
Notebooks and pens for participants
Water proof markers

**Preparations**
- Develop lesson plan with activities, roles and responsibilities
- Develop time-keepers schedule, with activities timed in minutes

**Preparation time**
- 1 hour to develop the lesson plans
- 2 hours for group practice

**Duration**
- 3 hours 15 mins

**Outline**
- Section I: Building a foundation for understanding the link between health and the social issues
- Section II: The community health profile
- Section III: Using local data to generate a profile of community health
- Section IV: Learning from the data
FACILITATOR NOTES
This module is intended to serve as a major introduction to the community’s vital statistics. By the end of this module, community leaders should understand what the major gaps in service utilization are and should be able to link this to:

- Social and behavioral barriers operating at household and community level
- Social inequities and social risks
- The health and well-being of mothers, children and families in their communities

Presenting facility data to the community

Prior to disseminating facility data, the facilitator should seek clarification on whether EGPAF has secured approval at the national levels for this activity. Should the national approvals be pending or denied, the facilitator should seek audience with the officers of the Health Promotion Unit and ask for their support with preparing the facility data to be shared.

In addition, the facilitator should ensure that staff members from the district hospital and/or the health promotions unit have prepared the data to be shared and are ready to respond to any questions. At the minimum, the facility staff should be informed of the community leaders’ institute, its aims and objectives, the content, the key audience and how the information they share will be utilized.

Helping community leaders make the links between issues

It is not enough to know how serious the health situation is in each community. The leaders must also be able to draw upon their understanding of the major social and behavioral barriers (gender inequity, stigma, discrimination, etc.). Facilitators should help community leaders to make the links between these dynamics and health outcomes by asking ‘why?’

On one level, the healthcare workers presenting these statistics should be asked ‘why?’ Healthcare workers should be encouraged to present a balanced picture, providing some insights into both the health system barriers and challenges, and the social and behavioral barriers and challenges. The facilitator should ensure that the healthcare workers’ responses are phrased as neutrally as possible, to minimize any confrontations or accusations targeted at the community leaders. The community leaders should be asked why they believe certain issues mentioned by healthcare workers (or the health promotions unit) are so entrenched and what can be done about them.

If time is limited...

If time is a limiting factor, the facilitator can opt to omit the segment ‘constructing a multi-level framework on health’ (marked optional). In this version of the lesson plan, the group discussion on what makes a person healthy can be held in plenary. In small group sessions, a similar discussion can be held on what makes families and communities healthy. The synthesis can be completed with facilitator guidance in plenary.
Part I: ‘Story of my life’ (Ice-breaker) (30 minutes)

Ask participants to imagine that they have just been contracted to write their autobiography for a major publishing company.

Directions:

• First, take a piece of flip chart paper and fold it in half and then in half again to form a book.
• Then choose the title of a popular song for the name of your book, which should be written on the front cover.
• On the inside of the front cover (page 2), write the name of the place where you were born, your community position, and the number of years you have been in that position.
• On page three, draw a portrait of your family or of someone very important to you.
• On the back cover (page 4), write about your community aspirations.

This icebreaker will help bring participants together through sharing their community experiences as they read their life stories to each other.

Part II: Introduce the module (10 minutes)

Explain that the previous modules have all set the stage for understanding what health is, the factors that contribute to good health, and the factors that limit or threaten health and wellbeing. In the following sections, we will explore the specific health issues in this community with the community leaders. Explain that it is vital to understand where we are starting and what the issues we are experiencing in this community, in order to attain wellbeing for everyone.

Explain that this section will include an introduction to the vital statistics of the community and discussions on the specific individual, family/household, community factors that influence these vital statistics. Explain that by the end of this module, the community leaders will have a full understanding of the health issues in their communities, from which they will draw in their future roles.

Part III: Group Discussion: What makes people healthy? (45 minutes)

Ask the participants to deliberate on the question ‘What makes a person healthy?’ Present questions in Box IV-1 as a handout or on a flip chart. Make it clear that there are no right or wrong answers.

<table>
<thead>
<tr>
<th>Box IV-1</th>
<th>Group Discussion: What makes a person healthy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What is a healthy person like?</td>
</tr>
<tr>
<td>2.</td>
<td>What are some of the factors that contribute to good health?</td>
</tr>
<tr>
<td>3.</td>
<td>What are some of the factors that contribute to ill health?</td>
</tr>
<tr>
<td>4.</td>
<td>Of the factors listed above, which are social and which are biological?</td>
</tr>
</tbody>
</table>
5. Are there differences in health status across different social groups? If yes, what are they? Why? What are some of the reasons for this?

6. What are the differences, if any, between the social and the biological (in born) causes of ill health?

Ask the participants to share their thoughts to each of these questions.

Next, ask the participants to divide into three groups (you can count off participants in threes). Within these small groups, ask participants to discuss what factors affect the health of individuals, families and communities. Ask participants to draw from real scenarios and situations in their communities. Each small group should list out these factors on flip chart paper and select a representative to share the discussions. Other participants should be encouraged to add additional elements that are not reflected on the flip charts. If there are any missing factors, probe the larger group to discuss these.

Section I: Building a Foundation for Understanding the Link between Health and Social Issues

Part I: Introducing the social dimensions of health (15 minutes)

Explain that social factors (such as education, employment status, income level, gender and ethnicity) influence how healthy a person is. In all countries, whether low-, middle- or high-income, there are wide disparities in the health status of different social groups. The lower an individual’s socio-economic position, power, and decision-making ability, the higher their risk for poor health is. It is useful to understand how these factors operate at the community level and how they link to health service access and, ultimately, health outcomes.

Part II: Constructing a multi-level framework for health (OPTIONAL) (1 hour)

Briefly explain that we will go into the group activity.

Prepare the following table on a flip chart. Display the table, which shows the different levels of society, up to the provincial level. Explain that listed below each level of society are the different determinants or factors that influence health. Ask participants to contribute factors that are not listed in the table.

<table>
<thead>
<tr>
<th>Individual</th>
<th>Family/ Household</th>
<th>Community</th>
<th>District</th>
<th>Provincial</th>
</tr>
</thead>
</table>
Divide the participants into five groups, and give each group five cards with different colors, each representing the various levels of social organization. Ask the group to identify factors that influence a person’s health at each of the social levels, based on what is happening in their communities.

The factors should be written on different cards, in writing that is large enough to read from a distance.

After a few minutes of deliberation, set up the five columns from the table on a large display board. Each group should take turns displaying their five cards. One member of each group should put up the group’s cards. Each group should add on new factors; they should not repeat factors that have already been mentioned.

After all the groups have put up their cards, each group should take turns illustrating the links between the factors. Each group may be asked to work through just one factor, linking it to the levels as well as to individual health.

Ask the groups that have worked on the important factors at the individual, household, community and district/province level to share their findings in the larger group discussion. One representative from each group should present the factors and include their strengths and weaknesses.

Finally, ask the participants to reflect on each factor and what their role in addressing each could be.

**Section II: Community Health Profile**

**Part I: Introducing the importance of the community health profile (15 minutes)**

Explain that every community has a history of responding to health issues in different ways. Ask the participants to share both the work that they are doing as community leaders and the work that they may not be fully involved in, but are aware of.
Explain that sometimes, these efforts may have a few issues such as:

Omitting to include the right groups

Trying to do too many things at once

Abandoning their efforts or losing interest too soon

Communities may be aware of some of the major health trends. At the same time, however, they may lack access to comprehensive information, and may not have opportunities to build deeper understanding of the key issues. To achieve sustainable health outcomes, it is critical that communities are empowered to link these insights with an understanding of the key demographic factors. Community leaders have a role to play in this.

Part II: Group Discussion: What makes communities healthy?

Ask participants to deliberate on the question ‘How healthy do you think your community is?’ Present the questions in Box IV-1 as a handout or on a flip chart. Reassure participants that there are no rights or wrong answers.

<table>
<thead>
<tr>
<th>Box IV-1</th>
<th>Group Discussion: How healthy is your community?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Are the members of my community generally healthy?</td>
</tr>
<tr>
<td></td>
<td>What are the major illnesses or health conditions that occur in your community?</td>
</tr>
<tr>
<td></td>
<td>What are some of the factors that contribute to good health in your community?</td>
</tr>
<tr>
<td></td>
<td>What are some of the factors that contribute to ill health?</td>
</tr>
<tr>
<td></td>
<td>Are there differences in health status across different social groups? If yes, what are they? Why? What are some of the reasons for this?</td>
</tr>
<tr>
<td></td>
<td>Are there groups who do not use health services as recommended, or who do not have access to health services? If yes, who are they? What do you think the barriers to accessing health service are?</td>
</tr>
</tbody>
</table>

Ask each group to select a representative to present the group consensus points.

Section III Using Local Data to Generate a Profile of Community Health

Part I: Using data to generate a profile of your community’s health

Explain that someone from the MOH is available to present the vital statistics from the local health facility. Introduce the MOH staff and his/her role. Explain to participants that the data that will be discussed is actual (real) data that reports the health status and health service use in their local areas. Ask participants to hold their questions until the end.
The health staff should reflect on the following minimum set of service indicators and link these to the trends in neonatal, child, and maternal deaths:

**Number of women attending ANC**

**Mean gestational age at first ANC visit**

**Number and percent of women who complete recommended 4 ANC visits**

**Number and percent of women who deliver in a health facility**

**Number and percent of women who receive PNC within 72 hours**

**Number and percent of women who receive PNC within 6 weeks of delivery**

**Number and percent of infants who attend child welfare visits 6-8 weeks after delivery**

**Immunization completion rates**

**Number and percent of male partners tested for HIV**

**Number and percent of HIV-exposed infants who receive HIV DNA-PCR testing for Early Infant Diagnosis in the first 2 months of life**

**Number of women re-tested for HIV during ANC and at delivery**

**Number and percent of HIV-positive pregnant women who receive ART or ARV prophylaxis**

**Number and percent of HIV-exposed infants who receive nevirapine (NVP) prophylaxis at birth**

**Part II: Leading communities to understand the health situation in their communities**

Ask participants to break into new small group arrangements (preferably with people who have not been in the same group during this session). Ask participants to discuss the following questions based on their understanding of the data:

- What are the key health statistics that surprised them?
- What are the key successes in maternal, child and family health in their communities?
- What are the key weaknesses in maternal, child and family health in their communities?
- Based on the data they have seen, what are the critical gaps (4 to 5 of the largest gaps in maternal, child and family health service utilization)?

**Section IV: Learning from the Data**

**Part I: Using the data to explore the information needs of different groups**

Next, each small group should choose the voice of a specific group in their community to represent. For instance, this could be pregnant women, HIV+ women, migrant men, mothers in law, first time parents, etc.

Ask participants to discuss the following questions:
• What are the 2 or 3 most important things members in this group should know about their health?
• What are the key knowledge, behaviors, and social issues driving the critical gaps identified above?
• If you were to ask communities to take a few key actions to address these groups based on social and behavioral factors identified above, what would they be? What has worked in the past?

Ask each small group to present a small role play or skit based on the key action messages they have developed for their interest group. What are the responses of other members of the group?

Part I: Recapping the module (10 minutes)

Recap the discussions in this module by reminding participants that health starts at the individual level. The health of a community depends on the decisions that individuals are willing and able or allowed to make over the course of their daily lives. Recap what we have learned about the health of this community. Recap some of the examples that the healthcare workers and the community leaders have shared that exemplify this.

Next, explain that in turn, the health of a nation depends on the decisions that households and communities support and are willing to make. Recall examples that participants may have shared over the course of the day. Recall examples of commitments that community leaders have shared throughout the institute up to this point.

Explain that we will spend the next half of the institute exploring the dynamics in our communities that may facilitate or inhibit good health. We will also explore the ways that community leaders can work together and their peers and superiors to drive momentum for health. Finally, we will explore ways that community leaders can work with their constituents for the health and wellbeing of all.

A Vision for Better Health for Women, Children and Families

Goal

The aim of this module is to help participants better appreciate the history, institutions and resources that already exist in their communities, and generate a shared vision on ways that these could be leveraged for improved health outcomes in their communities.

Key Competencies

By the end of this session, participants will:

• Use storytelling to reflect on the innate strengths of their communities, as used to solve past crises.
• Map formal and informal local service providers, tangible assets, and technical resources which could be availed for improved health outcomes for mothers and children in their community.
| **Materials Needed** | Module IV participant handout package  
Index cards (five different colors)  
Flip chart paper (15 to 20)  
Markers  
Notebooks and pens for participants  
Water proof markers  
IEC Materials |
|----------------------|---------------------------------------------------------------------------------|
| **Preparations**     | Develop lesson plan with activities, roles and responsibilities  
Develop time-keepers schedule, with activities timed in minutes  
Develop an illustrative map |
| **Preparation time** | 1 hour to develop the lesson plans  
1 hour for group practice |
| **Duration**         | 2 hours 30 mins |
| **Outline**          | Section I: What is possible in our community? Draw from past successes and achievements  
Section II: Community Services Assessment |
Facilitator Notes

The aim of this module is to ensure that the community leaders develop a shared vision for how the health of their communities could be improved. With the assistance of the facilitators, participants should draw enthusiasm and energy from the potential to make substantial improvements through small, concrete actions.

Facilitating the community services mapping activity

The services mapping activity should be a watershed moment in the institution, during which participants see the diverse assets and resources in their communities with new light and meaning.

The facilitator should encourage all participants to engage in this activity, including those who do not believe that the health sector is their strength or within their mandate.

The facilitator should explore resources that participants may not necessarily think of or easily consider, such as those that are no longer directly engaged in health or social service delivery. This might also include people who are not necessarily directly engaged in the health sector. These might include:

- Retired health professionals
- Retired social services professionals
- Change agents who have engaged intermittently in health issues in the past

Facilitators should also draw attention to the issue of traditional birth attendants if the discussion does not go in this direction naturally. It is important to draw upon this issue because at times, communities and their leaders may not designate certain people in this category. Yet, their services are being utilized.

Once the issue of TBAs has been raised, it is important to mention that the MOH has studied the issue of home births, and realized that the training and equipping of community cadres might not be making the contributions to saving mothers and newborn lives expected.

Section I: What is possible in our community? Draw from past successes and achievements

Part I: What is possible in our community? (45 minutes)

Explain to the participants that to start this module, they are now going to take turns reading about a community case study on how one community was able to rally around to address some of its most dire needs. Explain that these principles can be applied to any situation in health and to other challenges communities may face.
Case Study

The Madokero Case Study

Development agents were invited to come to Madokero by the local leader. He was concerned about the community’s increasing social challenges – violence, theft, and other vices were increasing rapidly, and the most promising youth from the community were leaving without returning.

The development agents held several meetings with local leaders and key administrative officials to make sure that they understood the full scope of these issues. They informed the local leaders that their first priority was to discuss the issues with other community members. A community meeting was called. The development agents started by asking members of the community to address the problems they were facing.

Among the problems that were mentioned included the declining ability of the land to sustain agricultural activities. Some community members noted that the local dam had been washed away during the previous year’s floods. Another key problem was the distance to the nearest health facility. As a result, many pregnant women had delivered outside the health facility due to lack of transport to ferry the patients. The youth in the community were roaming about due to poor employment options. The members of the community mentioned that, in the past, other development agents had raised their hopes. Numerous projects had started and ended without leaving a lasting change.

The development agents explained that their work is based on a different approach. Their approach is to understand the key local resources that could be used to solve the problems a community is facing, rather than starting special schemes that are short-lived and unsustainable. They challenged individuals to think critically about their roles and how they can contribute to their community’s needs.

Community members were led through a few stocktaking activities, including an assessment of the local resources and the community’s past experience in solving local problems. The citizens of Madokero took these suggestions to task. After close analysis, livestock was noted as a key natural resource. The members also noted that there were a few streams running through the community and a natural spring.

After assessing the locally available resources, the community decided that they could come up with a plan rather than wait for further direction from the development agents. The first priority was to construct a clinic so as to reduce the distance that the patients were covering in search of medical care. The community was convinced that collectively they could construct a health center. The idea mooted was that each village should contribute bricks towards the health facility construction.
In no time, the community gathered the bricks. They decided that the next step was making sure that pit and river sand should be made available. The ward councilor linked the community to government departments and builders from the army who were dispatched to assist in the construction. Having seen this community commitment, well-wishers brought in cement for the health facility. The villagers took turns to mix mortar for the builders to carry on with the work, and some local businesses contributed water for the construction process. Now the health facility is at window level.

All in all, the experience in this community has demonstrated that there is a role for everyone in international development, but it may require a bit of new and innovative thinking around what exactly those roles are. If outside organizations focus on what has been working - and build on that - the community may not be as poor and destitute as once thought. If empowered and given the opportunity, outside actors can facilitate genuine and meaningful change - defined, planned, undertaken and owned by the community itself. As this community - as well as countless others around the world - have illustrated, it's all in the lens you choose to use.

Lead participants through their reflections and responses to the key issues:
- Communities don’t exist in a vacuum – it is typical to have numerous pressing priorities
- Help the participants draw the links between this case study and what will be expected of them in the future
- Reinforce the fact that we are meeting to see how we can apply similar principles to the issue of health

Part II: Introducing the participants to the module (10 minutes)

Explain that throughout the rest of the module, we intend to discuss and equip community leaders with insights into the various technical resources that are available to support improved community health in their communities. Remind participants that a significant barrier to achieving better health outcomes is the poor coordination across partners, institutions and stakeholders.

Discuss the fact that while there is a clear coordination role and function at the national level, communities themselves can be in the driver’s seat by making sure that they know and relate to all the partners that operate within their boundaries.

Part III: Facilitating the discussion on past successes and achievements (45 minutes)

Introduce this section by explaining that we have looked at a hypothetical case study in which a community mobilized itself to solve its pressing needs. Now, we want to look at the actual experiences our communities have had in recently or in the past.
Ask participants to organize themselves into three or four smaller groups of members from the same or neighboring areas (wards, constituencies, or districts). In these groups, participants should identify a handful of critical events in recent memory that the community rallied to respond to. Ask participants to recreate a rough timeline of the event and how it unfolded from recognition to response.

Ask participants to share their memories of the events, how it was identified, the roles they and other community members played in addressing it and how people organized to improve their communities. Using flip chart paper, ask participants to discuss and list the reasons why people took action at that time.

Ask participants to reflect on questions like:

- What was the role of particular people in the community in making this a success? *(Identify specific group/community/individual/institutional strengths and capacities)*

- What was it about the situation itself? *(Describe the socio-political environment, the weather, local economic opportunity, the legal situation, cultural values, government policy, people’s past experience, etc.)*

- What was it about you that made it successful? *(People may be unwilling or too shy to talk about their own individual strengths and capacities, but they can reflect on the strengths and capacities of others)*

Next, ask participants to share the characteristics that members of their community have displayed. Summarize these as the strengths of the communities. With encouragement, these discussions will generate rich stories that reflect individual, group and community achievements, values and aspirations. The role of the facilitator is to help the group draw common themes from the stories and to begin to understand why the process unfolded as it did and to see the connections between the various community assets.

Afterwards, ask all the participants to work together to chart the successes achieved by their communities as one joint history or timeline. Ask participants to reflect on the strengths their communities have displayed in times of crisis and the emotions that they experience recounting these. Ask participants to discuss how these strengths can be revitalized and channeled for positive change, reflecting on their specific roles in this.

In the discussion after the activity:
Organize several flipchart papers to make the timeline (if time is limited, have each group present, but manage the activity by drawing the timeline yourself).

**Section II: Community Service Mapping**

**Part I: Explaining community services mapping (15 minutes)**
Explain that very often, the different programs and services in communities are not well coordinated. Some people may know more about the programs and services that exist, while other people will know less.

An interventions map is a map of services and activities in a community or location – for example, services and activities for pregnant women, or services and activities for children under 5.

Interventions mapping is useful to:

- Identify what relevant services and activities are available and who is responsible for them
- Explore people's knowledge and views of different services and activities
- Discuss who accesses services and activities and who does not
- Identify gaps in services and activities
- Explore people's priorities for new services or activities
- Identify organizations (and people) to involve in project planning and co-ordination

**Part II: Introducing the community services mapping activity (15 minutes)**

This activity is intended to describe the level of activities of various partners. We want to show the linkages between service providers. We also want to examine their relevance to the community.

Ask participants to break into small or medium-sized groups. There should be no more than six people in each group. Members should be from the same or related communities. Explain that the next activity is intended to take an inventory of all the service providers that support maternal, child and family health within their communities. These could be government offices, networks, coalitions, private services, alliances, traditional services, social services or financial services – as long as mothers, children and families can benefit.

On index cards, participants should write the name of a single service provider, the service they provide, and who they target. There should be only one service provider on the index card and no duplicate index cards.

**Part III: Facilitating the community services mapping (30 minutes)**

Next, ask participants to organize the service providers so that those that are internal to the community (grassroots, home-grown, or local) and community-oriented in practice are at the center. Those that are seen as external should be on the margins or boundaries of the community. Service providers that are linked should be close to each other, and can be grouped together. For instance, the members of a local network may be grouped under the heading of the network.

Finally, ask participants to draw relationship lines between groups of service providers, to represent resource flows, referral relationships, and/or communication lines. Service providers who have far reaching influence or reach/coverage should be emboldened.
Explain the following rules to the participants:

- When the partners on the map are closer to each other, they have closer working relationships (through a formal collaboration or funding arrangement)
- Partners towards the center of the map are critical to the community and embedded in the community
- One directional arrows show a one-way relationship between partners
- Two-directional arrows show a mutual relationship between partners
- Partners towards the edge of the map are active in the community but are not truly community-based (e.g. may not have local offices, may be international organizations, etc.)

Ask each group to present its map. Encourage additions to make the maps more complete and robust.

Ask participants to reflect on:

- Who is contributing to good health in the communities?
- Who is contributing to poor health in the communities
- Where are the links strong?
- Where are the links weak, and how can they be strengthened?
- How would the quantity and quality of services be described?
- If they placed themselves (CLs) on the map, where would they be? In the center? On the side? What links would they have?
- How can this scenario be improved?

Continue to reflect on:

- Who is contributing to health delays?
- Who is minimizing delays in uptake of critical services?
- Are there any outreach services?
- Are there any community-owned/community-led initiatives?
- What about things that were there in the past and left a lasting impression?

Ask participants to discuss:

- What does the map means for the health of families?
- How could the map be improved to strengthen and optimize the health of families?
- What could their roles be in achieving this?
- Write all of this on a flip chart paper

Using the ideas that have been discussed, paint a multi-dimensional picture of what the future could hold if funding, time and human resources were not a limitation.

**Part VI: Recapping the module (5 minutes)**

To recap this module, discuss the fact that health is not one single person’s responsibility, but the collective responsibility of all stakeholders in a community. This is achieved best when the different
stakeholders related to health are able to create an environment of mutual respect and partnership. By pooling together the limited resources each partner brings to the table, we can achieve more results faster, more efficiently, and more effectively. End the module by reflecting on the roles and responsibilities that community leaders have discussed, related to this. Explain that in the next module, we will discuss leadership style as a critical element that might facilitate or hinder this process.

Igniting Action – The community leaders as a team of champions

Goal  The aim of this module is to build team cohesion and a sense of shared purpose among community leaders representing different communities. The session aims to help participants to grasp the potentially transformative nature of the task they are about to embark upon.

Key competencies  By the end of this session, participants will be able to:

- Reflect on the leadership style needed to sustainably create social change
- Articulate a vision for working together as a team

Materials Needed  Module VI Participant Handout Package
Index cards
Flip chart paper
Markers

Preparation  Develop a detailed, timed facilitator’s schedule
Develop a clear lesson plan with clearly assigned roles and responsibilities
Group practice and detailed walk through of the lesson plan

Preparation Time  2 hours for initial sessions – this will decline substantially afterwards.

Duration  1 hour 45 mins
FACILITATOR NOTES

This module is important for several reasons. The community leaders will be using their influence to gather momentum for sustainable community schemes across different organizations and different groups. There might be a temptation to use suboptimal leadership styles to secure rapid momentum. Other community leaders might resort to harsh techniques. In addition, community leaders will be relying on others to lead the charge for them. In such cases, the leaders must be vigilant to abuses of power and ineffective leadership styles that might threaten the long term sustainability of initial community responses. Facilitators should seek and maximize opportunities to discuss this with the community leaders.

Addressing potential pitfalls

Facilitators should be vigilant for comments, remarks and attitudes that politicize the discussion on leadership. A good introduction to why we are addressing leadership is important. In addition, gently prod all examples away from the political. Emphasize examples and insights that apply to the community and its history.

Facilitators should also watch out for finger pointing and blame games which might quickly spiral out of control. As much as possible, participants should be instructed to omit names, party affiliations, and other such details, when drawing on scenarios that have occurred in the community’s past. Facilitators should try emphasizing the examples of good leaders from the community level. We may also need to probe for admirable leaders within communities, and utilize historical archetypes (only if they are neutral and depoliticized).

Finally, it is important to avoid making community leaders feel that we are instructing them or moralizing on their leadership. In discussing the pros and cons of each leadership style, facilitators should draw from the insights and discussions of the community leaders themselves.

Linking the folktale to the purposes of the module

After all leadership styles have been discussed, the facilitator may want to diagnose the lion king and find out how the leaders would have dealt with the issue.

Use of role-plays and skits to emphasize the characteristics of each leadership style

Facilitators and co-facilitators can improvise using brief skits to emphasize the pros and cons of each leadership style. To control the message, this should be done by the facilitation team.

Part I: Ice-breaker River (15 minutes)

Draw a line representing the seashore and ask participants to stand behind it. Explain what the line represents. When the facilitator shouts “River!” everyone jumps forwards over the line. When the leader shouts “Bank!” everyone jumps backwards over the line. If the facilitator shouts “Bank!” or “River!” twice in a row, participants who move have to drop out of the game.
Section I: Using Community Efforts to Improve MCH

Part II: The Tortoise, the Lion and the King – A folktale (30 minutes)

For this activity, ask participants to break off into groups of three to four. One person should read this article out loud whilst the others follow along. After completing, ask participants to discuss and reflect on the questions listed below.

One day Tortoise went out in search of food. He got lots of it, placed it in a sack which he tied to his leg and started pulling it home. Hare saw Tortoise with his sack and decided that he also wanted the food. He cut the rope that attached the sack to Tortoise and celebrated his good fortune. Tortoise was so upset that he took Hare to the king (Lion). Hare told the king that the sack did not belong to Tortoise because, if it did, he would be carrying it on his head. Lion agreed with Hare and, thus, Tortoise had to forfeit his hard-earned food. Tortoise began planning his revenge. When Hare began to move along the trail, Tortoise pounced on him, cut off his tail and celebrated his good fortune. Hare was so upset that he took Tortoise to the king. The king asked Tortoise what he had done, and he said that the tail did not belong to Hare because, if it did, then he would be carrying it on his head. The king was so dumbfounded that he could not do anything about this case.

Ask the participants to discuss the following questions:

- If you were Lion how would you have dealt with this case in the first place?
- Did Lion deal with this properly?
- We will discuss this further as we proceed

Part III: Introducing the discussion on leadership and community action (15 minutes)

Explain that under EGPAF, community leaders will be mobilizing numerous groups to initiate schemes that solve their health problems. All activities will be coordinated and guided by the Community Action Plan. The right leadership in each of these groups will be a critical factor in determining the success of the development and roll out of the Community Action Plan. There is a need to be vigilant against sub-optimal leadership in small groups and to address it as soon as identified. But first, we must agree on what type of leadership we are looking for. This module focuses on the repercussions of different leadership models. It also provides suggestions on effective communication skills for influencing and mobilizing community members.

Part IV: Exploring the qualities of good/bad leaders

Initiate the small group activity on the qualities of a good/bad leader. Allow some room for dialogue and use this to refine the existing lists. Have participants read each of the leadership styles and their effect on community members. Have them reflect on how this might affect what we want to achieve. Discuss whether the qualities listed differ for:

- Women
- Youth
Ask volunteers to take turns reading the leadership summaries below aloud, and lead the group through a reflection on each of the leadership profiles listed.

**Authoritarian Leadership**

This type of leadership believes that people work better when they are handed orders and is exercised by:

- Giving orders
- Demanding obedience
- Not listening to what other people think
- Not explaining the reasoning behind their orders and rules

**What happens when leadership is authoritarian?**

- The group members try to resist the leaders. Some of them may openly confront the leaders, while others may grumble behind their backs.
- When group members are unable to make their leader change, they do what the leader requests, but they do it slowly, without any passion and without showing any interest. Many of them drop out over time.
- The group loses its unity because members feel they are not listened to.
- People believe that they are not being developed or cared for as human being but treated like machines.

**Manipulative Leadership**

This type of leadership only thinks about self-interest, self-gain or self-benefit, even though there might be an initial pretense of interest in the group’s well-being.

**What happens when leadership is manipulative?**

- People who initially believe in the promises and commitment of this leadership gradually become disillusioned or disappointed, and generally lose all interest in participating in community life.

**Democratic Leadership**

Often, the perception is that democratic leadership is about being popularly elected or elected by a majority. While this is a part of democracy, true democratic leadership displays the following values:

- Perceives itself as playing a coordinator role but not being a boss
- Acknowledges the contributions of all members of the group
- Does not provide the solutions, but rather tries to assist members of the group in finding the right solutions that benefit the majority and not just a few
• Asks for everyone’s opinions before sharing their own
• Shares opinions in a humble way - as an additional contribution, not as a prescription for how things must be done
• Summarizes everyone’s opinions and proposals occasionally
• Asks questions and clarifies issues until the group reaches consensus
• Encourages everyone to contribute, gives everyone an opportunity to learn and collaborate

What happens when leadership is democratic?

• People enjoy working, they feel like their ideas are being taken into account
• People feel their contributions are valued
• People feel they are developing as human beings
• People feel they can achieve their goals and objectives, and that everyone has an important role to play in making this happen

Next, ask participants to discuss and reflect upon the following questions:

• What type of leadership tends to be the dominant model in our culture?
• What about the communities where we live and work?
• Do you think one type of leadership works in all situations?
• What type of leadership would we like to model as a team and in our communities?

Part V: Recapping the module (15 minutes)

Remind participants that in this module, we have explored how different leadership styles could hinder or hasten progress at community level. Ask participants to contribute some principles that they will commit to, and discuss ways to hold themselves and their communities accountable.
Community Planning for EMTCT and Maternal Survival

Goals
This module aims to help reinforce participants’ understanding of the importance of using data for community action. By the end of this session, participants should demonstrate an ability to critically analyze the strengths and weaknesses of a completed community action planning cycle.

Key Competencies
By the end of this session, participants will be able to:

- Articulate the community action planning process
- Assess their community’s readiness for joint action
- Anchor the community action plan in the evidence/data

Materials Needed
Module VII Participant handout package
Markers
Flip chart paper (three or four) with the community readiness tent drawn out
20 – 25 Index Cards
A box, hat or other container for the index cards
Handout package for case study

Preparation:
Develop a detailed, timed facilitator’s schedule
Develop a clear lesson plan with clearly assigned roles and responsibilities
Group practice and detailed walk through of the lesson plan
Flip charts with the community readiness tent

Preparation Time
2 – 3.5 hours for initial training sessions – this will decline substantially after initial trainings

Duration
2 hours 30 mins

Outline
Section I: Galvanizing Momentum for Family Health
Section II: Opportunities for impact - Action Planning for Rapid Results
Part I: Icebreaker: Match the cards (15 minutes)

Draw ten common animals that are found in the community on A4 pieces of paper. Remember the number of participants has to be even. If for example, there are sixteen participants then eight animals have to be used. Cut the pictures into two and throw them into a box. Mix them and ask participants to come and pick one paper each. Each participant should find the other part of his or her animal. The last pair to join their animal falls out of the game. It can be started over again.

Part II: Introducing the module (10 minutes)

Explain to the participants that, as previously discussed, if we want to help communities take ownership of health issues, they must understand their health status. However, this is only the first step. In order for health planning to be successful, we must understand how ready important stakeholders in the communities are for change. Based on this information, we may devise strategies and actions to neutralize potential resistance and apathy. We also can identify potential change agents and influencers. By giving these influencers a platform, we can build the foundations for successful action on health.

Explain that the activities in this module are intended to help us identify what the community’s acceptance of health issues is likely to be. We also will go through the community action planning process, and discuss how we can take advantage of existing planning processes at community level.

SECTION ONE: BUILDING MOMENTUM FOR FAMILY HEALTH

Part I: Building Momentum for Family Health (45 minutes)

The five essential components of community readiness for change in how issues are defined, by whom are they defined, how the district health team and community partners connect, communicate, and collaborate, the relationship between ‘the MNCH platform,’ and ‘the PMTCT platform’ for greater integration of the two, are described below. When these five components are aligned and are of shared certainty, there is greater likelihood of effective participation and successful implementation of the
work outlined in a team’s action plan. A series of questions to stimulate dialogue among stakeholders follow each readiness component.

1. **REASONING:** We can communicate a clear, compelling case for developing an Action Plan, based on its potential added value to the prevention of perinatal HIV transmission in our community.
   - What already has or is being done in your community to address your continuing women’s and children’s health issues? How effective are your current strategies and interventions?
   - How well do leading individual and organizational stakeholders in women’s and children’s health understand and agree upon the current situation?
   - What is the importance in using the collaborative approach at this time for improving the health of women and infants in your community?
   - Given multiple competing public health priorities in your community, how compelling is the case to advance perinatal HIV prevention at this time?

2. **RESULTS:** Together with key stakeholders in HIV/AIDS and women’s and children’s health, we can articulate what measurable results we expect to achieve through our team’s Action Plan, and when we expect to achieve them.
   - What are the desired results in your community for women’s and children’s health?
   - What is the expected time line for interim progress and finally achieving these results?
   - What measures will you use to assess progress and impact?
   - Do leading individual and organizational stakeholders in HIV/AIDS and women’s and children’s health understand and agree upon these measures, time lines and results?

3. **ROLES:** Essential stakeholders in our community can be mobilized to champion our Community Action Plan over time in their various roles as participants in change.
   - Who are the potential supporters and agents of the Action Plan in your community?
   - Who are the potential targets of the Action Plan in your community?
   - Are key supporters and agents willing and able to fulfill their roles in the promotion of the Action Plan in your community at this time?
   - Are targets and advocates of the HIV teams aligned with its supporters and agents?

4. **Advantages and Disadvantages:** There is strategic, sufficient balance between the potential benefits and possible consequences for essential community stakeholders to participate fully?
   - What are the risks and benefits of participating in the team’s local initiative (action plan)?
   - What are their incentives for genuine, sustained engagement?
   - Are these rewards sufficient to outweigh their perceived risks?

5. **RESOURCES:** There are sufficient systems and resources in our community to support full participation in women’s and child health activities, including implementation of an Action Plan.
• How much will it cost you, your team, your home institutions, and your community to participate?
• Are your champions willing and able to assure the systems and resources necessary to fully implement the action plan over time?
• Will you have enough dedicated time as champions of the implementation of the action plan in your community?
Summing Up: Our ‘Community Readiness’ Status

REASONING: We can communicate a clear, compelling case for doing the work outlined in our team’s Action Plan, based on its potential added value for enhancing perinatal HIV prevention in our city.

1 2 3 4 5
strongly disagree neutral agree strongly disagree

RESULTS: Together with our key partners, we can articulate what measurable results we expect to achieve through our Community Action Plan and when we expect to achieve them.

1 2 3 4 5
strongly disagree neutral agree strongly disagree

ROLES: Essential partners are willing and able to champion the work outlined in our Action Plan over the coming year.

1 2 3 4 5
strongly disagree neutral agree strongly disagree

RISKS AND REWARDS: There is a sufficient strategic balance between the potential benefits and possible consequences doing the work outlined in our Action Plan this year.

1 2 3 4 5
strongly disagree neutral agree strongly disagree
RESOURCES: There are sufficient systems and resources to support full implementation if we developed a Community Action Plan this year.

1. Transfer each of your agreement scales from the summing up sheet to the graphic above. Mark your score on each corresponding axis with a ☐.
2. Connect each of the five ☐ from axis to axis.
3. Shade the inside region from axis to axis.
4. Look at the shape of your ‘tent’: What does it tell you? Is there enough room to grow this initiative? Is it balanced? Is it able to withstand external elements that weigh down on its surface? Where is your greatest constraint?
SECTION TWO: OPPORTUNITIES FOR IMPACT – ACTION PLANNING FOR RAPID RESULTS

Part I: The EGPAF action planning model (45 minutes)

Explain to participants that their main task will be to drive for momentum on health action, focusing on ensuring the mobilization of others and carrying them along while observing that the following are accomplished:

- Taking stock of the health situation and understanding challenges and determinants
- Thoroughly and realistically assessing the social and economic strengths that communities can contribute to solving their own health challenges
- Emphasizing cross-sectorial collaboration – building deep and broad collaborations
- Building and celebrating early gains
- Taking a long-term view of the process
- Planning for the process to outlive the temporary project assistance (sustainability)
- Monitoring success using the available sources of data (health service uptake data)

Source: Coady Institute, 2008. ABCD Manual

The EGPAF community action planning model consists of four stages:

Exploring the issue

First 30 days. This includes holding concerted dialogue and advocacy to ensure that key stakeholders (such as policy makers, administrators, and opinion leaders) understand the health situation in their communities, its implications and its determinants. It also includes ensuring that community members themselves understand the key health challenges, their magnitude, and their impact. Finally, it involves helping key stakeholders and community members alike appreciate the successes that are being achieved.

Dialogue

Next 30 to 60 days. Concerted dialogue starts with self and collective reflection on the small actions we can take to initiate, support and sustain development. Community leaders will be expected to multiply their influence at this stage by working across groups, entities, organizations and institutions to encourage dialogue to take place. Marginalized, underserved and affected groups should also be targeted for inclusion at this stage, in order to ensure that their perspectives are not omitted.

Planning

Completed by the end of the first quarter. Community leaders will have the responsibility of collating perspectives from the exploration and dialogue processes, in generating a draft action plan. The planning process should be iterative, with wide dissemination of
the key elements of the plan, and broad input on the feasibility of moving to action. The focus of planning should be on joint responsibility and clear accountability for results, with strong focus working with the financial, technical, and resources that already exist. This should be an opportunity for brainstorming and innovation.

**Action**  
*In perpetuity.* Initial priorities should focus on small trials of creative solutions and personal actions which can be accomplished very early (first 30 to 60 days). The community can celebrate and draw inspiration and momentum from these. Opportunities for assessment, reflection, and celebration should be built in at this stage. If possible, it is important to take advantage of festivities, gatherings, and other ready opportunities. The community action plan should be evolving, focusing on three to five key priorities that can be feasibly tackled at a time. As the community gains confidence, the scope, complexity and ambition of the plans can increase.

**Part II: Recapping the module (15 minutes)**

Summarize the module by highlighting the fact that good planning includes making every effort to recognize the potential sources of resistance, and how to work with them. It also includes identifying the potential champions and advocates for key issues, and how to work with them. These are crucial leadership skills we hope to build upon and take advantage of in this work.

Explain that in the next module, we will engage in activities that help us plan the next steps forward and even start the action planning process as a team.

Thank participants for their contributions, thoughts and suggestions. Explain that their participation and engagement will be critical to the success of this intervention, and to the project as a whole. Explain that we look forward to using their ideas, insights and solutions in the coming days, weeks and months.

**Pulling all the Resources Together**

**Goals**

The aim of this session is for participants to analyze under simulation conditions, the critical actions that need to take place for the community action plans to be developed and deployed.

**Key Competencies**  
*By the end of this session, participants will be able to:*

- Articulate potential elements of their community action plan based on identified gaps and needs
- Identify the key constituencies of their communities and how to involve them in developing the community action plans
- Thoroughly critique a draft action plan and identify actions during its development and dissemination that could have been strengthened
**Materials Needed**

- Flip chart paper for small group discussions
- Markers for flip charts
- Simulation packets for three to four groups
- Simulation handouts for four volunteers
- Name tags for the simulations
- Four tables with chairs (to set up simulation stations)
- CAP Template
- Community Leader’s Diary Template
- Template for Work plan

**Preparation Time**

4 hours for initial training sessions – this will decline substantially after initial rounds of training.

**Duration**

4 hours 30 mins

**Outline**

- Session I – Conducting a force field analysis: Whose help will we need?
- Session II – Developing a community action plan: A simulation exercise
- Session III – Committing to Action: The Action Chart

**FACILITATOR NOTES**

The aim of this module is to prepare the community leaders for their eventual roles and responsibilities in the intervention.

In addition to the customary preparation for this module, facilitators should be fully conversant with the participants’ profiles, including their educational and literacy levels. Every provision should be made to ensure that participants who cannot read and write are well accommodated. If literacy levels are low, or there are a number of participants who do not feel comfortable writing, a member of the facilitation team should be designated as a scribe.

In such a case, participants should be reassured that their thoughts are being captured by recapping the consensus points before writing them down, reading any points that will be documented on behalf of the group as they are written, and reading any points that are written on behalf of the group afterwards.

The facilitators should ensure that the next steps to be taken by the project are clear. The schedules for future meetings, including any one on one support, should be clarified and shared with the participants before the institute is wrapped up.
Part I: Ice breaker – The Shopping List (10 minutes)
Ask participants in the group to form a large circle. One person starts by saying “I am going to the market to buy… (fish).” The next person says, “I am going to the market to buy fish and… (potatoes).” Each person repeats the list, and then adds a new item. The aim is to be able to remember all of the items that the people before you have listed.

Part II: Introducing the module (10 minutes)
Explain to the participants that we have reached the last series of activities in the institute. We have learnt about the reasons why families experience catastrophic health issues. We have also shared the ways that households and communities can contribute to these scenarios, either making them better or worse. We have learnt the tremendous ways in which communities can be a force for good.

Now, we want to spend a substantial amount of time brainstorming how we can prepare for and apply the decisions and suggestions that we have shared as a group. The discussions we will have in this module will sow the seed for our work in the months and years ahead.

Part III: Conducting a force field analysis: Whose help will we need? (10 minutes)
It is essential to take stock of who or what can help bring about change (the ‘supporting’ factors) and who or what may prevent change (the ‘resisting’ factors). Weighing the strength of ‘supporting’ factors and the strength of ‘resisting’ factors and planning to either take advantage of these factors or neutralize them is critical for implementation success.

Explain that the purpose of this activity is to help participants identify the supportive and resisting factors that may affect implementation of their community action plans.

Ask participants to divide themselves into groups of four or five. The entire group should choose one example of an action or activity that could be in a community action plan. For instance, an activity could be organizing water brigades to fetch water in shifts for the local health clinic.

Discuss the supporting factors and resisting factors. For example, a community planning a water brigade may identify a supporting factor as ‘there is a borehole 2 km from the local clinic’. A resisting factor to this may be that ‘people do not want to cooperate with the clinic nurse because she is considered to be very hostile’.

Explore a complete list of the supporting and resisting factors. Draw or write each supporting and resisting factor on a separate card. Take one card at a time. Discuss the strength of the factor on the card. For example, the fact that the rains are frequent and heavy in this area may be a strong supporting factor.

On a piece of flip chart paper, draw the force field as a vertical wavy line. Label the space on the left ‘supporting factors’. Label the space on the right ‘resisting factors’. (In an alternative version, you can divide the flip chart paper into two – one side is the green grass, the other is the brown/dry grass).
Place each card on the force field. Draw a line from the center of the force field to each factor. The length of the line shows the strength or weakness of each factor; the longer the line, the stronger the factor and the shorter the line, the weaker the factor.

**Part IV: Discussing the Results of the Force Field Analysis (20 minutes)**

When the activity is complete, discuss what the force field shows. For example, how can the group build on the supporting factors? Which groups are critical to reinforcing the supporting factors? What can the group do to overcome the resisting factors? Which resisting factors are within the group’s control? Which factors are outside the group’s control? Which groups must be reached to limit the resisting factors? Which groups should be reached to address the factors that are outside the group’s control?

**Part V: Developing our community action plan (70 minutes)**

Explain to the participants that the group is going to engage in a series of activities that will prepare us for the collective task that lies ahead.

Explain that all the facilitators will be available to assist participants. Explain that in order to manage time better, we will need to break into small groups. Read the following steps to the participants, and ask for questions. Ensure that the steps each group is intended to take are clearly understood.

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**Step I**

Ask each group to explore and discuss the challenges to maternal and child health. They should take into consideration the vital statistics that have been shared from their locality, and the discussion of what issues are driving poor health outcomes and low service utilization.

The group should come up with a list of ten (10) issues that pose a major challenge to attaining good health for mothers, newborns and their children.

**Step II**

Next, each group should agree upon one challenge from their list of ten (10) to focus on. The best challenge to focus on is one that meets the following criteria:

- It can be readily addressed using the community’s resources
- It can be solved in a reasonable amount of time
- It is directly related to an important or critical health issue (i.e. it is directly linked to the health of mothers, newborns, children, and families)
- Solving it can result in improvements for the most possible people

It might take a process of elimination to arrive at the one single important challenge. Ask participants to use a two-step process to arrive at the single issue: First, through discussion, they should eliminate the challenges that don’t directly meet the criteria specified above. They should be able to easily strike of a
few problems this way. Next, through a ballot system or other such devise, they should select the single most important challenge from the list of 10. Each time they vote and discuss, the challenge with the lowest votes should drop off the list. If the votes are unanimous, there is no need to further rank and sort.

Ask participants to document why they have selected the specific challenge that emerges.

**Step III**

Ask participants to identify the critical steps that need to take place to solve the challenge that has been identified. *Whose buy-in needs to be sought? What resources need to be brought together? Which champions and allies could be engaged? Who needs to be convinced? What actions need to take place? What are the timelines?*

**Step IV**

Ask participants to reflect on the action cycle that has been presented, and align these steps accordingly.

**Step V**

Ask participants to draw a rough plan that puts together all these actions. The plan should indicate the persons responsible for the actions, the key roles and responsibilities, the resources needed, and the timelines for achieving these.

**Step VI**

Next, ask participants to reflect on these action plans, checking on how feasible they will be to complete with the resources, finances, time, and opportunities that are available in their communities.

**Step VII**

Ask participants to share these plans in plenary, and give the other groups and opportunity for review.

Reflect on this process. Emphasize the fact that the plans should be guided by the data on what the most pressing priorities in their communities are.

Also ask participants to reflect on:

- How easy was it to come up with the list of 10 challenges and make sure they are linked to the vital statistics that have been presented from their areas?
- How easy was it to come to consensus on the single challenge to pick?
- What processes they used to come to consensus?
- How easy was it to come up with the critical steps to solve that challenge?
- What processes did they use to identify the critical steps?
- What did they learn from the group critique process?
Activity VI: Case Study – Sabhuku Mukurudziri Makes an Action Plan (40 minutes)
For this activity, ask participants to break off into groups of three to four. Each group should read and review the case study notes in the handout package. A mock action plan is included in each package, with the health services data from the Sabhuku Mukurudziri Primary Health Unit, and brief background notes. Given what they have learned about Sabhuku Mukurudziri, ask participants to thoroughly critique the draft community action plan. This should take approximately 30 minutes.

After completing this, ask participants to break out of the small groups and assemble for a plenary reflection and analysis. Discuss and reflect on the questions listed below:
- What are the strengths and assets of the Sabhuku Mukurudziri community?
- What are the main health challenges faced by Sabhuku Mukurudziri?
- How does Sabhuku Mukurudziri’s action plan align with the community’s major health challenges?
- What do you observe about the community leadership team?
- What do you observe about the community action planning process?
- What are some ways the action plan could be strengthened?

Part V: Committing to Action: The Action Chart (40 minutes)
The action chart is the last activity and is critical for getting the participants to commit themselves to take action after the workshop. Reinforce the fact that a critical outcome of this entire workshop is sustainable, long term change at the community level.

Draw the action chart on a sheet or piece of flip chart paper. Ask participants to write down their commitments under each of the sections of the action chart, indicating their initial after each commitment. These commitments should be based on the implementation cycle that has been discussed previously.

Participants should make commitments that are realistic and feasible. Participants should denote a time schedule for each commitment, thinking about what is possible to accomplish within the next thirty days, the next ninety days, and before the end of the year.
Actions that I can take to promote change at the personal and interpersonal level:

What skills/strengths do I have that I can use to promote the change?

What support do I need?

Actions that We (group) can take together to promote change at the community and policy level:

What skills/strengths do we have that we can use to promote the change?

What support do we need as a community?

Activity VII: Practice using Community Leader’s tools (40 minutes)

Explain that because of the nature of the project, we are putting an emphasis on documentation. It is important that the activities the leaders implement be carefully documented, so that we can track how the communities are being mobilized. We also want to track how they are responding to the advice they are being given.

Furthermore, emphasize that while the documentation will be important to us, it will be more important for the various community members and structures. There is no pressure to have the most activities documented. Our goal is to have complete documentation and to support community leaders to submit this in time. We also want to support community leaders in ensuring that the work they are doing is well known and disseminated at all levels.
Explain that we have two simple tools to help community leaders capture their activities on a day to day basis. The first of this is the Community Leaders’ Diary (hand out copies of the diary or point out which page in the participants’ handout). Explain that the diary will provide a reference point during our routine community leaders’ forums. Introduce the diary step by step, and respond to any questions.

Next, introduce the community action plan. Stress that the community action plan is meant to be a living document. We expect that the community action plan will be completed for each community. However, priority actions will then be selected at the cluster level. Explain that the CAP is intended to be updated routinely. It should indicate which activities are proposed, which are started, and when they are completed. In addition, explain that the CAP should reflect the activities of numerous groups. These groups can be included as long as they have agreed to join forces to address the health of families in the community. Discuss the fact that the community leaders will be sharing their CAPs with each other. Remind them that progress will be discussed through the monthly/quarterly forum meetings. Lastly, stress that the resources for supporting the actions in the CAP should ideally come from existing sources in the community or from the government. Remember to explain why we have taken the viewpoint that it is best to use other existing resources (sustainability).

Next, explain that we will be taking information from the tools every time we have a meeting with them. Emphasize the importance of accurately depicts the true picture of community health schemes.

**Activity VIII: Wrapping up the institute (20 minutes)**

Explain that we have come to the end of the community leaders’ institute. Thank participants for their contributions. Explain that we would now like to map the next steps with the participants.

Mention the fact that the community action plans and their implementation will be the focus of all efforts for the next quarter. Revisit the schedule on how the community action plans will be developed:

**First 30 days:** This includes advocacy to increase appreciation of the health situation in their communities, its implications and its determinants. This should start with presentation of the process to their home constituencies. Eventually, this should reach policy makers, administrators, and opinion leaders.

**Next 30 to 60 days:** Community leaders will plan dialogues with various groups. These dialogues will ensure individual and collective reflection on the small actions we can take to initiate, support and sustain health.

**End of the first quarter:** Community leaders will have the responsibility of collating perspectives from the exploration and dialogue processes, in generating a draft action plan. The planning process should include wide dissemination of the key elements of the plan.
Emphasize the fact that the EGPAF team will be available to provide some level of assistance in the next few months, especially in the first quarter. This will start with the monthly meetings to review success and go further in depth on some of the issues that were introduced during this institute. Ask participants to discuss and agree upon a series of dates and times when we can have follow-up meetings.

Explain that during these meetings, we will have an opportunity to discuss the issues that community leaders have requested more information on. Ask participants whether they have a preference for issues and topics to be discussed further. Use this information to develop a schedule for the monthly/quarterly forum meetings.

Explain that the program assistants will also include some visits throughout the month. Ask participants to clarify their expectations on how the program assistants might be of help over the coming months. *Initiate workshop closing proceedings such as the vote of thanks, closing prayer, and any housekeeping issues.*
Community Leader Refresher Training

1.0 Introduction

The community leader intervention is intended to support community leaders to take more ownership and control of health activities in their communities. This includes advocating with social, political and administrative stakeholders. Most importantly, leaders are being equipped to find practical solutions using community engagement and mobilization processes. Communities are facilitated to contribute their own resources to implement these solutions which can include time and ideas.

Community leaders should undergo a 5 day training program, using the Community Leaders Manual (CLM), prior to undertaking of community engagement and mobilization activities in their communities. Community leaders need to be supported by program staff that mentor and give them feedback on a quarterly basis.

This three day refresher training is designed to refine facilitation skills and improve knowledge on MNCH messages in the core technical modules. The training program is not a repetition of entire module as covered during the initial training; instead, it is tailored to the skills and knowledge gaps identified from quarterly reports as well as midterm group discussions with community leaders.
Each country team should focus on the tools and skills that are most relevant to the needs of their community leaders (refer to the attached summary of needs and their implications for the training program).

2.0 Self-skills assessment (1 hr)

2.1 Completing Skills Assessment Sheet (15 minutes)

Facilitator instructions

- Ask participants a week before training to individually complete the two tables on the Skills Assessment Sheet (Appendix1). Collect the information and review for skills listed as needing attention by participants; skills where most participants scored below three will have to be revisited.
- Review and adjust the refresher schedule to include the skills gaps revealed by the self-assessment

2.2 Group work: CLE successes and challenges (45 minutes)

Facilitator instructions

- Divide the community leaders into three groups to reflect on their successes and challenges from the Community Leader Engagement experience. All three groups should answer the following questions:
  1. What were the successes you achieved through implementing this intervention?
  2. What were the challenges you encountered during implementation of community leaders intervention?
  3. What lessons have you learned about CLM, what recommendations would give to EGPAF if we were going to redo this intervention?
- After group discussions, each group should present their work in plenary.
- Allow time for questions and discussion after each presentation.
- Summarize the successes and challenges. Assure the participants that the schedule will be adjusted to ensure that they are better equipped to address the identified challenges after the refresher.

The Health Rights module is one of the four community leader manual modules together with Gender Inequality, Stigma and Discrimination, and a Vision for Better Health of Women, Families and Communities, all of which will be revisited in this training. Each module can be completed in a two hour session.

3.0 Module 1: Health Rights (2 hrs)

Objectives

After revisiting the health rights module, community leaders will be able to:

1. Identify the key health policies guiding eMTCT
2. Recognize community roles towards health facilities and health staff
3. Lead community discussion on the main health challenges in eMTCT delivery and possible community level solutions
4. Explain the concept of right to health and patient’s charter

**Methodology/ Activities**

**Ice Breaker: Nine Dots-Straight Line (10 Minutes)**

First prepare the nine dots on flip charts, arranging the dots in a square matrix of three rows and three columns. Ask the participants to come in turns to join the nine dots without lifting their hand and using only four straight lines. After they have tried and failed to join the dots, ask them to help each other and try to join the dots as a group. Solve the riddle if necessary.

Once it is solved, ask participants to reflect on the meaning of the riddle. Entertain all responses. Explain that the riddle showed us that if we think outside of the box, we can creatively solve seemingly impossible questions (another alternative meaning of this activity can be provided: if participants reflect closely on the solution, it looks like an umbrella, symbolizing that fact that we all are under the same umbrella, working jointly to create solutions).

**3.1 National Policies (35 mins)**

National health policies play an essential role in defining a country’s vision, priorities, budgetary decisions and course of action for improving and maintaining the health of its people\(^1\). It is important for communities to understand their role in health. A key aim of EGPAF is to help communities understand the main health challenges and highlight ways that they can be solved at community level.

**Facilitator Instructions**

- Give participants the above stated definition of health policy
- Ask participants to name any specific national policies they are familiar with.
- Hang up the flipcharts with the list of health policies.
- Go through the list of the health policies highlighting the objectives of each policy, referring participants to the appropriate pages in their handouts.
- Close the session with comments on the importance of knowing the health policies that supports their work as community leaders.

**3.2 Group Work: Health system constraints and community expectations (35 mins)**

**Facilitator Instructions**

- Divide the participants into small groups of four to five.
- Ask participants to reflect and discuss the following questions in their groups:
  1. Given the objectives of the policies/plans shared above, how well equipped are the local health facilities they are familiar with? Consider staff levels, drug supplies, drug costs, laboratory services, client flow, and facility adequacy from the previous activity.
  2. What are some of the situations that hinder better health provision at the local health facilities?
  3. What specific actions can communities take to support health facilities and health staff? Are these already ongoing? What are some examples?

\(^1\) [http://www.who.int/nationalpolicies/en/]
• Allow each group to present a summary of the answers to the three questions.
• Summarize the possible barriers and community support to the health system in delivery of elimination of mother to child transmission (eMTCT), highlight answers from the presentations and add any that may have been left out.
• In closing, remind participants that community members have expectations of health facilities. The group work shows the constraints and realities that health facilities have to meet community expectations. As community leaders we will create strategies and key messages to help manage community expectation without dampening demand and enthusiasm for critical services.

3.3. Discussion: Main Policy Frameworks and Concepts (30 mins)

Part one: Definition of health

Facilitator Instructions
• Ask participants how they would define health. After a few contributions, share and explain the WHO definition:

“Health is a state of complete physical, mental and social well-being and not merely his absence of disease or infirmity.”

• Next, ask participants what they think right to health means. After a few contributions, share and explain the following definition: “The right to health means everyone is entitled to the highest attainable standard of health.”

Part two: National Patients’ Charter

Facilitator Instruction
• Ask participants to work in pairs and take turns to read the Patient’s Charter. Each pair should write down parts of the charter that they find difficult to understand.
• Collect all the papers, tabulate on a flip chart, read the charter and explain each segment, emphasizing parts that participants highlighted as difficult to understand.
• Engage participants in discussion about what they find interesting about the charter, share a life experiences about the using the charter since the last training session.
• Close the session by reminding participants of importance of understanding definitions of health and all the rights in this charter.

4.0 Module 2: Gender, Stigma and Discrimination (1hr 30 mins)

Objectives

After revisiting the module on Gender, stigma, and discrimination the community leaders will be able to:

1. Describe the health inequalities and gender inequities in their communities.
2. Distinguish how men differ from women in their health experiences and their engagement with health services.
3. Recognize the effects of stigma and discrimination at community level, and how they hinder progress on community health.
4.1 Group Work: Sharing Experiences on Health Inequalities

Facilitator Instructions

- Request participants to gather in groups of two to four, preferably with people who are from the same area or community.
- Ask participants to spend a few minutes to think and make a list of groups in their communities who tend to have worse health, worse access to health services, or cannot afford the health services they need. Invite participants to report back on their discussions.
- Take note of any groups that are consistently mentioned by the different groups.

If participants do not mention them, inquire about the following groups:

- Orphans and vulnerable children
- Women living with HIV
- Avoidable deaths amongst young women
- HIV exposed children etc. (Find out if they exist and why their health might be considered to be worse off than others?)
- Summarize the session with an input on patterns and conclusions that contribute to health inequity across different communities. Refer to patterns from participants presentations and include any that may have been left out

4.2 Gender and Health (30 mins)

Facilitator Instructions

- Ask participants how they would define gender and gender norms.
- After a few contributions, share and explain the definitions as follows:
  - Gender: refers to the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for men and women.
  - Gender norms: Gender norms are a set of “rules” or ideas about how each gender should behave. They are not based in biology, but instead determined by a culture or society. It is important to remember that gender norms can be very different from one culture to another
- Inform participants that the country is concerned with how men and women differ in their health and in their engagement with health services.
- Explain that there is increasing attention to the fact that the way our communities raise men and women influences their behaviors, which in turn influences their wellbeing.
- Ask participants for examples of sayings or actions that are common in the communities that suggest that men are raised to be strong and should avoid any displays of weakness and the ones that suggest women are raised to be pious and stoic, with no acknowledged identity if they are not married.
- Write down the contributions on a flip chart. Take a few examples from the list and explain how gender norms affect health. For example men may not pay attention to important signs of illness until it is too late, because the belief that men they should avoid any displays of weakness. Similarly women may remain in unhealthy/abuse marital relationships because of the belief that women are raised to be pious and stoic, without an acknowledged identity if they are not married.
- Explain that gender can be defined as the range of physical, mental, and behavioral traits specific to and defining of the difference between male and female. Explain that
the differences between men and women often have very deep cultural and traditional roots. They are influenced by the values of the culture.

4.3 Group Work: Stigma and Discrimination (30 mins)

Facilitator Instructions

- Place pictures of stigma scenarios on tables around the room.
- Divide the participants into groups of two or three people.
- Ask each group to walk around and look at as many pictures as possible.
- Open this section describing that stigma is a process that points out or labels differences (e.g. stating or thinking that “He is different from us – he coughs a lot”). It links differences between people to negative or undesirable behavior (e.g. stating or thinking that “His sickness is caused by his sinful and promiscuous behavior”). Finally, it separates ‘us’ and ‘them’ through shunning, isolation, and rejection. It creates or reinforces loss of status and discrimination (loss of respect, isolation).
- State that we all know what stigma is. We stigmatize when we say things like “she was promiscuous” or “he deserves it”. We also stigmatize when we do things such as isolating people when they get sick, and excluding them from decision-making.
- Ask participants how they personally describe stigma. After taking a few responses, summarize the responses by stating that to stigmatize is to label someone; to see them as inferior because of an attribute they have.
- Ask participants what the main causes of stigma in the cases they have seen are. Fill in the gaps. The responses should include:
  1. Insufficient knowledge, misbeliefs, and fears about HIV transmission
  2. Moral judgments about people
  3. Fears about death and disease
  4. Lack of recognition of stigmatizing actions
- Point out that there various types of stigma that can occur in communities; self-stigma, felt-stigma, and discrimination.
- Ask participants what they think the terms mean.
- Explain that self-stigma, occurs when people experience self-hatred, shame, blame; or when people isolate themselves from their families and communities because they feel they are being judged by others so. PLHIV go through this, especially immediately after diagnosis.
- Define felt-stigma as when people have negative or harsh or judgmental perceptions or feelings towards specific groups such as PLHIV. Finally, there is discrimination, where people actually act on their negative feelings and attitudes and put their thoughts into action.

Key Message

- Stigma occurs, through:
  1. Physical and social isolation from family, friends and community
  2. Gossiping, name-calling, violence and condemnation
  3. Loss of rights and decision-making power
  4. People blame and isolate themselves
  5. The whole family, friends, and associates are affected by stigma
6. Judging people and assuming things about them based on their looks, appearance, type of occupation, or lifestyle

4.4 Drama Skit: Stigmatizing Acts

Facilitator instructions

- Tell participants that the facilitation team will present a brief drama skit. Act out the skit according to the guidance notes (a more appropriate skit could be developed based on the needs of the community).
- Ask the community leaders to reflect on what they think the message of the drama skit is. After a few responses, ask them to share why they think people stigmatize. If responses are not naturally forthcoming, probe by asking them to reflect on cases they have witnessed or hear of in their communities.
- Explore some ways that the participants themselves might have stigmatized others in the past, by judging, calling people names, etc.

Key Message

- Stigma and discrimination hinders community health;
- In plenary, ask community leaders to discuss the effects of stigma and discrimination at community level, and how they hinder progress on community health.
- Ask them to share some of the ways that they could contribute to addressing stigma and discrimination.
- Recap the Module (5mins)

5.0 Module 3: Health Primer (1hr 30 mins)

Objectives

Community leaders will be able to explain:

1. The reproductive health issues in their community
2. The trends of deaths during pregnancy, labor, and breastfeeding

Methodology/ Activities

Icebreaker: What has changed- What did we learn out of the icebreaker (10 mins)

5.1 Introducing the Module- (10 mins)

Facilitator instructions

- Request that participants sit quietly and reflect for a minutes. Ask them if they have witnessed or heard of a recent death of a young woman (Between 19-45 years old) in their community. This death should not be due to an accident, surgical complication, murder or suicide.
- Ask a few participants (four to five) to recount the stories and give the reason why the death occurred. On a flip chart list the main reasons for the death in each story, where the death took place and who was providing care at the time of the death.
- Focus on the deaths that were due to pregnancy, and explore the above issues to find out if there were any major barriers to effective care. This can include early warning
signs that were missed, the time it took to get care and any other factors that contributed to the death.

- Ask participants to indicate some factors that are preventable.
- Explain that reproductive health issues are of concern because:
  1. Many pregnancy risks are also associated with sexual health issues (some STIs can cause miscarriages and issues such as poor fetal development, uterine fibroids can affect fertility and the safety of the fetus).
  2. Child health can be affected by poor sexual health (children can be exposed to different types of STIs).
  3. Some STIs can lead to cancer in both men and women.
- Conclude the session with the following key messages

**Key Message**

- Trends for deaths during pregnancy, labor, and breastfeeding are very high in many communities. These deaths are largely preventable.
- A range of factors increase the risk of death for pregnant women, including poor reproductive health choices, lack of awareness, poor compliance with clinical recommendations, and poor response to the critical danger signs during this period.
- The economic costs of death of mothers for families and communities are high – families often spend tremendous amounts. The deaths and disability due to all these factors can be easily prevented or managed.
- Everyone from community leaders to community members has a role to play in addressing this, as highlighted and discussed in the last module (remind participants of the discussion on the obligations and duties of individuals and communities).
- We will examine these in depth in this module, and also discuss the critical points at which family members, community members, and community leaders could intervene to save mothers’ lives.

### 5.2 Story telling on unsafe abortions

**Facilitator Instructions**

Narrate the following story:

*Mary is a 14 year old girl. She is in 9th grade at a prestigious boarding school. After the December holiday she went back to school and after a few weeks she realizes that she is pregnant. She knows who the father of the child is, but she is scared that she will be harmed if she discloses his identity.*

- Ask the participants the following questions:
  - Put yourself in Mary’s shoes: what do you do, who do you talk to?
  - Let participants suggest possible people she could talk to.
  - So let’s say Mary has talked you, her confidant and senior at school.
  - As a friend what do you say to her?
- Close with someone who tells her to go and see the old woman in a nearby village that can ‘take care’ of her pregnancy.
- Ask participants to discuss the issues in their communities, and their encounters with similar scenarios.
- The group should reflect on the following questions:
  1. How common is teen age pregnancy in our communities?
2. What are the usual outcomes of teenage pregnancy? Would most girls in such a situation opt for unsafe abortion? Why?

3. What are the implications of teenage pregnancy and unsafe abortions for educational institutions, parents and community leaders?

4. What actions can schools, community leaders, and families take to redress this crisis?

**Key Message**
- Unsafe abortions are a leading cause of maternal mortality in many parts of the world.
- Abortions are illegal in Uganda and in Zimbabwe, with very few exceptions. Even for these exceptions, the protocols for qualifying are quite extensive: the client needs two letters from licensed medical practitioners (doctors) attesting to the medical necessity. They must also receive approval from the high court.

5.3 Maternal Health (30 mins)

**Facilitator Instructions**
- Ask participants to share who in their communities is primarily responsible for maternal health and why. Ask specifically about the role of the partner, the extended family, and the community.
- Explain that one of the key measures of maternal health is the number of women who die during pregnancy or within forty-two days of delivery. Explain in the same way, to assess child health, we track: the number of children who die within twenty-eight days of birth; the number of children who die within one year of life; the number of children who die before their fifth birthday.
- Keep these definitions on flipchart paper and place it in a prominent and central location so that the participants can reflect on these definitions.
- Share the relevant data with the participants. Explain that there are many care and prevention practices that families and communities observe around the time of labor and in the postpartum/neonatal period.

5.4 A discussion on direct and indirect causes of maternal and child mortality

**Facilitator Instructions**
- Ask participants to share what they think the main causes of maternal deaths are. Recap these (they include: Severe bleeding; prolonged and obstructed labor, infections after childbirth, high blood pressure, and unsafe abortions.
- For each of these, link with the key indirect causes (some of these include community level practices discussed earlier).
- Explain that most child deaths occur during the first 28 days of life, when children are at their most vulnerable. Ask participants to share what they think the main causes of child deaths are. Recap these (they include: preterm birth, complications during delivery, pre-term complications, birth asphyxia (halted breathing at birth), infections (most commonly sepsis, meningitis and tetanus); and congenital defects. For each of these, link with the key indirect causes (practices at community level).
5.5 A discussion on home births (25 mins)

Facilitator Instructions

- Ask participants to define what a home birth is. Emphasize that a home birth is any birth outside an accredited health facility. Encourage participants to reflect on how common home births are and the dangers associated with them.
- Request that participants reflect on the following questions:
  1. How many deaths have been due to home deliveries (or births outside the health facility) in their communities?
  2. How much they believe that delivering at home contributes to deaths in their communities?
  3. Are any specific women that are at a disadvantage?
  4. Why do these home births occur? What are the social issues that surround home vs. health facility birth? What are the barriers within the health sector?

5.6 Discussion: eMTCT as an important component of MNCH

Facilitator Instruction

- Discuss the prongs of prevention of mother to child transmission (PMTCT) (Contextualize this to what is the role of the community leader in making this happen).
- Discuss importance of male involvement (Already discussed so just refer to the discussed points).
- Explain the key services women receive from antenatal care through delivery, emphasizing PMTCT as part of the package. Refer to the participants’ handout package.
- Also explain the key child health interventions, emphasizing PMTCT as part of the package.

Key Message

- The government has committed to putting programs and infrastructure in place to ensure that new infant HIV infections are reduced to almost zero.
- This is possible with the new drug combinations, if pregnant and breastfeeding women are immediately placed on lifelong ART after being diagnosed.
- An important benefit of this regimen is that HIV’s contribution to maternal mortality can also be drastically reduced.
- Women can only get PMTCT services from the health facilities; these services are not available at traditional healers.

Recap Module in 5 minutes

6.0 Module 4 - A vision for better Health for Women, Children, and Families (1 hour)

Objectives

By the end of this module participants will be able to:

1. Explain the various technical resources that are available to support improved community health in their communities.
2. Understand effect of the poor coordination across partners, institutions and stakeholders on health outcomes at community level
3. Recognize the coordination role and function of communities in relation to partners that operate within their boundaries.

Methodology/ Activities

6.1 Introducing the module
Facilitator Instructions
- Explain that in this module, we intend to equip community leaders with insights into the various technical resources that are available to support improved health in their communities.
- Remind participants that a significant barrier to achieving better health outcomes is the poor coordination across partners, institutions and stakeholders.
- Discuss the fact that while there is a clear coordination role and function of partners at the national level, it is community responsibility to be in the driver’s seat of making sure that they know and relate to all the partners that operate within their boundaries.

6.2 Case study: What is possible in our community? (20 mins)
Facilitator Instructions
- Let participants take turns reading a community case study about how one community was able to rally together to address some of its most dire needs.
- Explain that these principles can be applied to any situation in health and to any other challenges communities may face.
- Remind participants that communities don’t exist in a vacuum, so it is typical to have numerous pressing priorities at any given point in time.
- Help the participants draw the links between this case study and what will be expected of them in the future.
- Reinforce the fact that we are meeting to see how we can apply similar principles to the issue of MNCH.

6.3 Discussion on past successes and achievements (15 minutes)
Facilitator Instructions
- Ask participants to organize themselves into groups of three or four members from the same or neighboring areas (wards, constituencies, or districts). In these groups, participants should identify a handful of critical events in recent memory that the community rallied to respond to.
- Ask participants to share their memories of the events or threats, how they were identified, the roles that they and other community members played in addressing the event or threat and how people organized to improve their communities.
  - What was your role? (if applicable)
  - What was the role of particular people in the community in making this a success? (Identify specific group/community/individual/institutional strengths and capacities)
• What did you do to make it successful? (People may be unwilling or too shy to talk about their own strengths and capacities, but they can reflect on that of others.)
• Ask participants to reflect on the strengths their communities displayed during a time of crisis, and the emotions that they experience recounting these.
• Ask participants to discuss how these strengths can be revitalized and channeled for positive change, reflecting on their specific roles in this.

6.4 Group work: Explaining Community Services Mapping (25 mins)
This activity is intended to describe the level of activities of various partners. We want to show the linkages between service providers. We also want to examine their relevance to the community.

Facilitators Instruction
• Ask participants to break into small or medium-sized groups. There should be no more than about six people in each group. Members in a group should be from the same or related communities.
• Explain that the next activity is intended to take an inventory of all the service providers that support maternal, child and family health within their communities. These could be government offices, networks, coalitions, private services, alliances, traditional services, social services, or financial services - as long as mothers, children and families can benefit.
• On index cards, participants should write the name of a single service provider, the service they provide, and who they target. There should be only one service provider on the index card, and no duplicate index cards. (They should keep these cards and you will give them instructions on what to do next)
• Ask each group to draw a map of their community and indicate where the service providers on their index cards operate from.
• Ask participants to answer the following questions:
  • What relevant services and activities are available, and who is responsible for them?
  • Who has access to these services and activities, and who does not?
  • Identify gaps in services and activities.
  • What are people's priorities for new services or activities?
  • What organizations (and people) should be involved in project planning and coordination?
• Invite the groups to present their maps and answers to the questions in plenary
• To wrap the group, ask participants to comment on:
  • What does the map means for the health of families?
  • How can the map be improved to strengthen and optimize the health of families?
  • What could their roles be in achieving this?

6.5. Concluding Community Services Mapping (15 mins)
Facilitator Instructions

- Explain that very often, programs and services in communities are not well coordinated. Some people know more about programs and services that exist, while others will know less. Ask participants to reflect on:
  - Who is contributing to good health in the communities?
  - How can this scenario be improved?
  - Who is contributing to poor health in the communities?
  - Who is contributing to health delays?
  - Where are the links strong?
  - Who is minimizing delays in uptake of critical services?
  - Where are the links weak, and how can they be strengthened?
  - Are there any outreach services?
  - How would the quantity and quality of services be described?
  - Are there any community-owned/community-led initiatives?
  - If they placed themselves (CLs) on the map, where would they be? In the center? On the side? What links would they have?
  - What about things that was there in the past and left a lasting impression?

7.0 Process for Conducting Advocacy on MNCH Issues

STEP 1

- Establish a process for assessing and understanding the challenges and needs of the target population. Before embarking on an advocacy effort, it is important to understand the challenges that the affected population faces in gaining access to the services and support it needs for improved health. To get this information, community leaders can rely on data that already exist or employ their own survey mechanism. Methods for collecting data need not be complex and could take the form of focus groups or meetings with members of the affected population. However, these methods must be reliable enough to ensure that advocacy goals will address the real problems faced by the people that community leaders seek to serve.

STEP 2

- Identify changes that will address the needs of the community. Sometimes, a policy already exists that could alleviate a health issue, so focusing on improvement or enforcement is more effective. Community leaders should conduct a policy scan to identify existing policies on MNCH issues of interest.

STEP 3

- Community leaders have the power and influence to change policies that address the needs of the target population. To improve MNCH issues, community leaders must identify who else has the influence and power to make the desired changes. Such people could include elected or appointed officials, social or government staff, or representatives of international

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* Adapted from PLAN(2009)
bodies. Often, gaining the support of just one influential person can be the key to a successful advocacy effort.

**STEP 4**
- *Determine why the desired change has not happened in the community.* Maybe there are other issues that are receiving much higher visibility in the media and among the community. Maybe the issue is poorly understood in the community and the community leaders and members need to understand the extent of and solutions to the problem. Whatever the reason, the answer to this question is critical to developing an effective advocacy strategy.

**STEP 5**
- Community leaders must *find ways to address the concerns and make people understand why it is important to support MNCH efforts* in the community. Allies who have the trust of the concerned groups can help to allay their fears; this may affect who is engaged in outreach.

**STEP 6**
- What makes the community leaders to be best suited for carrying out an advocacy initiative? What are their areas of strength in comparison to other organizations? Does the team have strong communications support? There is no “right” or “wrong” way to do advocacy—some people are better suited to play certain roles than others. *Understanding the community leaders’ power* can help define the most appropriate role for their advocacy and enhance its effectiveness.

**STEP 7**
- *Identify others who have a similar interest in addressing the problem.* Partnerships with others who are seeking similar changes and who have the resources, influence, expertise, or community strength that could benefit advocacy efforts can be very valuable. Patient groups can offer a powerful voice in conveying the impact of a health issue, and professional organizations can often provide access to experts that enhance credibility. Faith-based and community leaders can be influential with policymakers, while business leaders are better positioned to influence others. And in many cases, activist groups and advocacy organizations can provide the strategy and strength needed to move an issue forward on the political agenda.

**STEP 8**
- *Identify the advocacy activities and messengers* that are most likely to influence those with the power to effect the desired change. Advocacy activities should be matched specifically to the target audience in the community. Policymakers who are responsive to public opinion may be influenced by media campaigns, social mobilization strategies, petitions, and rallies. Radio and television shows, newspaper inserts, and editorials can increase awareness in communities. Public events that recognize a community leadership can be especially effective in transforming support into action. However, the messenger is as important as the message. Personal testimonials are very valuable in media outreach.
STEP 9

- *Assess current and future resources* that could be accessed to pursue these activities and change in the community. The scope and timeframe for advocacy activities must be informed by the resources available to carry them out effectively. Money is only one resource to consider. Do the community leaders have access to the expertise, influence, and people necessary to carry out the proposed MNCH activities? A small, strategic advocacy effort that engages the appropriate people with the necessary skills and connections is more likely to be successful than a large mobilization and media campaign that lacks financial support or communications expertise.

STEP 10

- *Determine how to evaluate progress and success.* Advocacy initiatives often seek to achieve easily measured outcomes such as MNCH issues. It is important, however, to also measure incremental gains in community awareness, interest, and support. Increased awareness can be measured by how often there are reports on such issue in the outlets accessed by the target audience. Political interest can be evaluated by the number of public statements or references to an issue made by a policymaker. And political support can be documented through the adoption of health priorities into national plans, line items inserted in budgets, and introduction of new regulations and guidelines.

8.0 Conducting Community Dialogues

A community dialogue is a process of joint problem identification and analysis that aligns community and stakeholders’ actions towards a preferred future for all. A community dialogue is an interactive participatory communication process of sharing information between people or groups of people aimed at reaching a common understanding and workable solution. Unlike debate, dialogue emphasizes listening to deepen understanding. It develops common perspectives and goals and allows participants to express their own views.

8.1 Principles of community dialogue

- Community dialogue is based on two main principles: problem-based adult learning and negotiation.
- Adult learning recognizes that individuals will go for things that are relevant to them; they have a lot of knowledge, skills and experience, which can be built on or improved. People like to be respected and will eagerly participate in issues that affect their lives.
The dialogue focuses on solving the problem together based on existing experience, capabilities and opportunities, rather than pre-determined messages that must be communicated by one party and received by the other. All partners, service providers, and the community may experience behavior change in the process of this dialogue.

8.2 Other principles include the following:

- Sensitivity to local, family and community experiences: working by invitation and commitment and not imposition.
- Facilitation rather than intervention of experts.
- Use of participatory approaches with space for listening, inclusion, agreement and expressions of concerns.
- Respect for differences and mutual trust.
- Willingness of facilitators to engage in a process of self-development.
- Working in partnerships with non-governmental and community based organizations.
- Belief that communities have the capacity to identify needed changes, own these changes and transfer change to other communities.
- Grounding in universal human rights.
- Gender sensitivity, a focus on participation and inclusion of women and girls.
- Mutual learning (facilitators with community, community with facilitators, community with community, among community members, organization to organization.

8.3 Differences between debate and dialogue

<table>
<thead>
<tr>
<th>Debate</th>
<th>Dialogue</th>
</tr>
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<tbody>
<tr>
<td>Denying opposing views</td>
<td>Allows expression of different views.</td>
</tr>
<tr>
<td>Participants listen to refute views of other people.</td>
<td>Participants listen to understand and gain insight.</td>
</tr>
<tr>
<td>Questions are asked from a position of certainty.</td>
<td>Questions are asked from a position of curiosity.</td>
</tr>
<tr>
<td>Participants speak as representatives of groups.</td>
<td>Participants speak with free minds.</td>
</tr>
<tr>
<td>Statements are predictable and offer little new information.</td>
<td>New information surfaces.</td>
</tr>
</tbody>
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8.4 Objectives of conducting community dialogue

The main objective of community dialogue is to generate response from communities and individuals that result into commitment to addressing the identified problems (issues)/gaps in a participatory manner.

Community dialogue aims at:

- Generating deeper understanding of the nature of the epidemic among individuals and communities in order to influence change.
- Surfacing common issues and the resources to address them, (helps identify barriers to positive change and uncover innovative ideas).

• Building a pool of resource persons with transformative leadership abilities and facilitation skills to scale up the community response to HIV and other related development issues.
• Providing a forum for the unheard to be heard.
• Promoting social contacts among various groups in the community.
• Promoting self-esteem, self-confidence, tolerance, trust, accountability, introspection and self-management.
• Promoting ownership and accountability.

8.5 Benefits of conducting community dialogue

• It helps identify and enlist key individuals for sustainable partnerships.
• It helps solicit community participation, support and commitment in problem solving for sustainable behavior change.
• It promotes the sharing of information and ideas between individuals of different cadres and backgrounds.
• It facilitates joint community assessment to identify community problems and effective solutions.
• It promotes deeper understanding of communities, their situation, current practices, interests, existing opportunities and challenges for sustainable behavior change.
• It promotes skills building of the facilitator in the development and maintenance of effective dialogue with the community in order to facilitate joint decision making and problem solving for sustainable behavior change.
• It helps to generate local media attention.
• It helps leaders of all sectors to recognize their roles in building sustainable healthy communities.
• It promotes accountability and ownership of agreed interventions.

8.6 Methodologies and tools

The community dialogue approach is adapted to suit the participants’ level of knowledge and skills. The following methods may be used depending on the topic and assessment of participants’ capabilities:

• Strategic questioning.
• Story telling.
• Historical timelines.
• Mapping and transect walks.
• Traditional Wisdom (Proverbs, songs).
• Discussions

8.7 Steps for conducting community dialogue

• Problem Identification
• Problem Analysis
• Identification of Options
• Planning Together
• Acting Together
• Evaluate Together
8.7.1 Problem identification
The first step in conducting a community dialogue is to identify the problem or issue at hand. In this case the issue could be MNCH with HIV testing and counseling (HTC), human rights or gender. It could be poor hygiene and sanitation due to lack of clean water and sanitary facilities.

At this point the team will identify current problems/issues. What the community is doing about these issues, whether the actions are giving the required outcomes and what are the constraints/challenges faced by the community.

The gaps between the preferred behavior and current practices will determine what will be required to address the problem.

8.7.2 Problem analysis
- Problem analysis involves a thorough analysis of the issue/situation at hand. Questions that can be asked under this section include:
  - What are the causes of the problem/issue at hand?
  - Is the issue/problem a shared problem in this community or it is perceived as a problem for only a few?
  - How is the community responding to the problem? What is the community’s current knowledge? What are current attitudes, practices and beliefs about the issue at hand?
  - Has the community previously dialogued on the issue? Have traditional, religious and political leaders been involved in trying to address the problem/issue at hand?

8.7.3 Identification of the best options
This section shall assist the user to identify the best options. In doing this, emphasis is placed on the actions that need to be taken to achieve the intended behaviors and how to sustain them.

Identified options are prioritized based on their effectiveness, feasibility, relevance and appropriateness within the community’s context.

8.7.4 Joint planning
At this planning stage participants will examine the priorities set during the previous step before designing an appropriate Community or Village Action Plan.

The plan will include the following elements:
- What will be done?
- When it will be done?
- Who will do what?
- Resources required and potential challenges.
- Measures or indicators of success.
- Participatory tools for monitoring and evaluating actions.

8.7.5 Acting together
After collectively developing an action plan, implementation of the plan should be conducted in a participatory manner, with each member recognizing her/his role in the project. It is therefore important to build commitment of the various community members and stakeholders in order to ensure the success of the project.
8.7.6 Monitoring, evaluation and feedback
Participatory evaluation involves a collective reflection of achievements, identifying what went well and why particular actions did not go well. Participatory evaluation creates a learning process for the program recipients, which helps them in their efforts. After the evaluation process the necessary feedback should be provided. This promotes ownership of the process and the will to do better next time. Reinforcement is also important to motivate participants to do better or sustain the desired behavior.

9.0 Using Information from Dialogues to Develop Community Action Plans

Methodology/ Activities

9.1 Developing the Community Action Plan

Facilitator instructions

• Explain to the participants that the group is going to engage in a series of activities that will prepare them for the collective task that lies ahead.

Step 1

• The group should come up with a list of five to ten issues that pose a major challenge to attaining good health for mothers, newborns, and their children using information they compiled from the dialogues.

Step 2

• Next, each group should agree upon one challenge from their list to focus on. The best challenge to focus on is one that meets the following criteria:
  1. It can be readily addressed using the community’s resources.
  2. It can be solved in a reasonable amount of time.
  3. It is directly related to an important or critical health issue (i.e. it is directly linked to the health of mothers, newborns, children, and families).
  4. Solving it can result in improvements for the most people.

• It might take a process of elimination to arrive at the one single important challenge. Ask participants to use a two-step process to arrive at the single issue. First, through discussion, they should eliminate the challenges that don’t directly meet the criteria specified above. They should be able to easily strike off a few problems this way. Next, through a ballot system or other such devise, they should select the single most important challenge from the list of 10. Each time they vote and discuss the challenge with the lowest votes should drop off the list. If the votes are unanimous, there is no need to further rank and sort.

• Ask participants to document why they have selected the specific challenge that emerges.

Step 3

• Ask participants to identify the critical steps that need to take place to solve the challenge that has been identified. Whose buy-in needs to be sought? What resources need to be
brought together? Which champions and allies could be engaged? Who needs to be convinced? What actions need to take place? What are the timelines?

**Step 4**
- Request participants to reflect on the action cycle that has been presented, and align these steps accordingly.

**Step 5**
- Ask participants to draw a rough plan that puts together all these actions. The plan should indicate the people responsible for the actions, key roles and responsibilities, resources needed, and the timelines for achieving these.

**Step 6**
- Next, ask participants to reflect on these action plans, checking how feasible they will be able to complete with the resources, finances, time, and opportunities that are available in their communities.

**Step 7**
- Ask participants to share these plans in plenary, and give the other groups and opportunity to review.
- Emphasize the fact that the plans should be guided by the data on what the most pressing priorities in their communities are.
- Also ask participants to reflect on:
  - How easy it was to come up with the list of 10 challenges and make sure they are linked to the vital statistics that have been presented from their areas.
  - How easy it was to come to consensus on the single challenge to pick
  - What processes they used to come to consensus
  - How easy it was to come up with the critical steps to solve that challenge
  - What processes they used to identify the critical steps
  - What they learned from the group critique process

10.0 Community mobilization for adoption and implementation of Community Action Plans (CAP).

This session builds on the previous session on CAP development. The session provides a process for putting together a CAP adoption forum and presents CAP development, adoption and implementation in the context of community mobilization.

10.1 Community CAP Adoption Process
Methodology/ Activities

**Facilitator instructions**
- Ask participants to share their definitions of community mobilization (CM). Wrap up the brainstorming with the USAID definition, which defines CM as, “A capacity building process through which community members groups or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve the health and other conditions, either with their own initiative or stimulated by others”. (USAID, 2007)
• Explain that CAP development, adoption, and implementation are critical parts of the community mobilization process. They require buy in of various segments in the community, including community leaders and opinion leaders, local, state, and professional groups, religious groups, businesses, and individual community members.

• Categorically state that the community leader’s role does not end at the development of the CAP; it is also their responsibility, with support from the community action team (CAT), to get communities to buy the CAP for adoption and implementation. An effective way to get community and stakeholder buy in is through a CAP adoption forum, using the following process
  ▪ The community leaders and CAT should send out invitations to whole community and stakeholders for a CAP adoption meeting, through appropriate community invitations styles including radio, posters etc. The objectives of the meeting (getting community input in the MNCH CAP) should be clearly stated in the invitations
  ▪ The Adoption Forum/ meeting should follow a workshop format with time for presentations and interaction with various community groups.
  ▪ During the meeting, the CAP should be read out and community members given time to analyze the CAP in working groups (Stake holders, Youth, Adult men, and Adult women). Every group is requested to input their ideas to the CAP and to present their group work for adoption by the wider community.
  ▪ Following the presentations, the CL and CAT should incorporate the community input and update the CAP.
  ▪ The final document will be presented to the community meeting and signed off by stakeholders and representatives of community groups. The signing off indicates community commitment to implementation of the CAP, it should be done publicly during the community meeting.
  ▪ The Adoption Forum may be long depending on the size of the community, CL should be prepared to request additional time to present the adapted CAP for final adoption and signing off by all stakeholders and community at large

**Key message**

• The EGPAF project community leaders intervention has followed the community mobilization process through leadership training, formation of community action team, development and implementation of CAPs

Community mobilization empowers communities to create change and to take some action on issues affecting their lives.

• Development, adoption and implementation of community action plans are an important parts of a community mobilization process.

11.0 Appendix

11.1 Skills assessment Sheet
Table 1: Skills acquired during the Community Leaders Manual training

Indicate skills acquired during training and skills acquired after training from community engagement and the level of masterly for each skill.

<table>
<thead>
<tr>
<th>Skills</th>
<th>Acquired during Community Leaders Manual training</th>
<th>Acquired through mentoring/after training</th>
<th>Level of mastery (1-3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Contacting other community leaders</td>
<td></td>
<td></td>
<td>1 as not well mastered, 2 as well mastered, 3 as very well/perfect</td>
</tr>
<tr>
<td>2. Introducing EGPAF programs at non EGPAF meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Mobilizing community members to come for community dialogues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Facilitating community dialogue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Documenting results of community dialogues in the diaries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Extracting information from diary to CAP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Conducting community dialogues to follow up CAP implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11.2 Three Day Refresher Training Schedule

Meeting Chair:

Session 0: Welcome, Introductions and Orientation

8:30-9:00 Opening Remarks, review of agenda, ground rules, and participant introductions [name] Country Director

9:00-9:15 Purpose of the Refresher Training [name]

9.15-9.30 Ascertaining Skill Levels of Community Leaders [name]

9:45-10:05 Group Discussions on Challenges and Lessons Learned [name]
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:05-10:30</td>
<td>Presentations of Challenges and Lessons Learned</td>
<td>[name]</td>
</tr>
<tr>
<td>10:30-10:45</td>
<td>Tea Break</td>
<td></td>
</tr>
<tr>
<td>10:45-12:15</td>
<td><strong>Session 1: Core Technical Modules</strong></td>
<td><strong>[Name], Intervention Coordinators</strong></td>
</tr>
<tr>
<td></td>
<td>Rights and Health</td>
<td>Group Discussions (Focus on discussions of Overview of the National Policy Overview of the Patient’s Charter) [name]</td>
</tr>
<tr>
<td>12:15-1:00</td>
<td>Health Primer and Group Discussions</td>
<td>[name]</td>
</tr>
<tr>
<td>1:00-2:00</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Session 1a: Core Technical Modules</strong></td>
<td><strong>[name], Intervention Coordinator</strong></td>
</tr>
<tr>
<td></td>
<td>Health Primer</td>
<td>[name]</td>
</tr>
<tr>
<td></td>
<td>Afternoon Tea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gender Inequality, Stigma and Discrimination</td>
<td>[name]</td>
</tr>
<tr>
<td></td>
<td>Afternoon Tea</td>
<td></td>
</tr>
<tr>
<td>4:00-5:00</td>
<td>A Vision for Better Health for women, families and communities</td>
<td>[name]</td>
</tr>
<tr>
<td>8:30-8:45</td>
<td><strong>Session 2: Conducting Community Dialogues</strong></td>
<td><strong>[name], Intervention Coordinator</strong></td>
</tr>
<tr>
<td></td>
<td>Recap of Day I</td>
<td>[name]</td>
</tr>
<tr>
<td>8:45-9:15</td>
<td>Presentations on Conducting Community Dialogues</td>
<td>[name]</td>
</tr>
<tr>
<td>9:15-9:30</td>
<td>Tea Break</td>
<td></td>
</tr>
<tr>
<td>9:30-10:30</td>
<td>Role Plays on Conducting Dialogues</td>
<td>[name],</td>
</tr>
<tr>
<td>10:30-11:30</td>
<td>Process for Conducting Advocacy on MNCH Issues &amp;Role Plays</td>
<td></td>
</tr>
<tr>
<td>11:30-12:30</td>
<td><strong>Session 3: Using Information from Dialogues to Develop the Community Action Plans</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>How to identify key challenges and Action Steps for the CAPs</td>
<td>[name]</td>
</tr>
<tr>
<td></td>
<td>Group Work Plenary Discussions</td>
<td>[name]</td>
</tr>
<tr>
<td>12:30-1:15</td>
<td>How to identify Persons Responsible, timelines, resources and status of proposed action:</td>
<td>Group Work and Plenary Discussions[name]</td>
</tr>
<tr>
<td>1:15-2:00</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>2:00-3:30</td>
<td><strong>Session 4: Community Mobilization for Community Action</strong></td>
<td><strong>Intervention Coordinator Intervention Coordinator</strong></td>
</tr>
<tr>
<td></td>
<td>What is Community Mobilization</td>
<td>[name]</td>
</tr>
</tbody>
</table>
### Session 5: Community Mobilization for Community Action

**Intervention Coordinator Intervention Coordinator**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9:00</td>
<td>Recap</td>
</tr>
<tr>
<td>9:00-10:00</td>
<td>How do we mobilize for; Sharing the CAP</td>
</tr>
<tr>
<td></td>
<td>Community action? Who should be targeted?</td>
</tr>
<tr>
<td>10:00-12:00</td>
<td>How do we present the CAP?</td>
</tr>
<tr>
<td>12:00-1:00</td>
<td>Closing Remarks</td>
</tr>
<tr>
<td>1:00-2:00</td>
<td>Lunch and Departure</td>
</tr>
</tbody>
</table>

#### 11.3 PowerPoint Presentation on Community Mobilization and CAPS

**What is Community Mobilization?**
- Community mobilization is a process, not a once-off event.
- Brings together various segments of the community to form partnerships and focus on a pressing community issue.
- Issues include not limited to health, social, or other developmental issues.
- The various segments brought together include community leaders and opinion leaders, local, state, professional groups, religious groups, businesses, and individual community members.
- Community mobilization empowers individuals and groups to take some kind of action to facilitate change.

**Steps in the Community Mobilization process**
1. Building partnerships
2. Raising Awareness on the issue
3. Building and formalizing partnerships
5. Present the Action Plan to the community
6. Implement the MNCH Community Action Plan
7. Review and reflect on Your Community Actions

**Step 1: Initiate partnerships**
1. Find people in your community who will volunteer their time to join MNCH Community Action Team. Invite them to your first Community Action Team meeting, during first meeting agree on group objectives.
2. Decide the best time and place for gathering.
3. Set clear goals and objectives for each gathering.
4. Have at least 3 meetings with the same people (this is more effective than a one-time event).
5. Make sure there are no more than 25 people per activity to ensure in-depth discussion.

**Step 2: Raising Awareness on the issue**
- Ask where in our community are challenges affecting MNCH?
- Draw a map of the community that shows places where MNCH challenges are. You may want to include:
  - The roads and open spaces
  - Homes, schools and other meeting places
  - Xs on the map where the challenges of MNCH are high
  - This map tells you about where to focus your Community Action Team activities and what groups might be most at risk.

**Step 3: Build and formalize partnerships**
- Identify people in your community who you will consult about developing your MNCH Action Plan.
- You can meet with:
  - District health, education and welfare managers
  - Health workers
  - Traditional leaders
  - Community organizations
  - School teachers and parents
  - Church members and leaders
  - Youth (in and out of school)
  - Elderly
  - Plan when you will hold meetings with these people in your community.

**Step 4: Make Community Action Plans**
1. Invite and hold meetings with the people identified in Step 3.
2. Start the meeting with Community Action Team Objectives. Then ask people:
   - What do you not understand about MNCH? Make a list
   - How are MNCH problems affecting our community?
   - What are people dealing with MNCH problems?
   - What some ideas for prevention activities?
   - What can you do at home, work or in the community?
   - Take meeting notes and bring them back to the next Community Action Team meeting.
11.4 Example of Community Dialogue Guide Used

Uganda Community Dialogue Guide

EGPAF Community Dialogue Guide for the Community Leaders

A key aim of EGPAF is to help communities understand the main health challenges and highlight ways that they can be solved at community level.

Project rationale: We want to learn how interventions can be designed to effectively address the needs of families and communities. We emphasize that in order for mothers and children to have the best health, their health must be everybody’s business, from fathers, in-laws, and neighbors to the community leaders and healthcare workers.

Project goals: Our goals are to increase demand for, uptake of, and retention in maternal, neonatal and child health (MNCH)/ the elimination of mother to child transmission of HIV (eMTCT) services to improve country progress towards elimination of pediatric HIV/AIDS.

Under Community Leaders Engagement intervention, the community leaders and their communities come together to discuss:

- The problems/barriers to MNCH/PMTCT services
- Ways to solve them
- Materials needed
- The time it will take and,
- The persons who will be responsible for the work.

All these discussions will help us develop a Community Action Plan which will outline a work plan detailing the major activities our community leaders will carry out to address the key MNCH/PMTCT issues identified in our communities. The community leaders will first focus on the identified MNCH/PMTCT issues in the CAP that require the least resources, and time to implement compared to those which will need the most resources and time.

We believe that if we can address the following issues, we will save many lives in the community and ensure that:

- All pregnant women complete 4 ANCs as recommended by the government
- All pregnant women deliver at the health facility
- All fathers care about their health, and take the necessary tests to protect their wives and babies
- All mothers to comply with directions and adhere to any medications they are given
- All parents to ensure that children receive the medications they are given
- Children come back for a health visit 6 weeks after birth
- New mothers come back for a health visit soon after birth i.e. within one and a half months
- Mothers test for HIV and if found positive, they take the necessary medication and precaution for PMTCT.
Discussion questions

1. Why do you think it is important for mothers to complete four ANCs as recommended by the government?
2. Why do you think it is important for all pregnant women to deliver from a health facility?
3. Why do you think it is important for fathers to also care about their health and take the necessary tests?
4. Why do you think it is important for mothers and children to go back for a health visit after six weeks?

Note: The community leader needs to emphasize the importance of each of the above after community members have given their views.

Now that we have seen the importance of each of the above, I would like each of us to raise their hand and state:

1. The issues/barriers that are preventing mothers, children and families from accessing health services during pregnancy, delivery and child care.
2. How can we address the above mentioned barriers?
3. Out of the issues mentioned, which do you think we should prioritize or focus on the most?
4. What resources do we need (locally available) to address them?
5. How and where can we access these resources?
6. How long will it take us to address these issues?
7. Which people will be responsible at each stage of addressing the issues?

Note: Community members may not state all the issues, you need to probe so that they clearly explain these problems and also probe for the action steps.

We have four village ambulances that are based and available for use in Kirima, Nyamirama, Kanyantorogo and Kayonza:

- The village ambulance is based at ... (mention your sub-county and the EGPAF health facility it’s based at).
- The overseer of the village ambulance is .... (Mention the name of all overseers with their contacts so that they can easily be reached).

Under the Community Days we provide an opportunity to bring some services closer to the communities for men, women and pregnant women and children. The minimum service package is always HIV testing and referral – in addition, there are diagnostic (and not curative) services such as blood sugar testing, growth monitoring, and screening for high blood pressure and TB. Here we shall also work with the community leaders to identify existing organizations and health facilities in their communities that implement or to provide MNCH/PMTCT services. We believe that if we work with existing MNCH/PMTCT services providers in our communities, more people will be able to receive comprehensive MNCH/PMTCT services. Therefore, we want to know:

- Are there other MNCH/PMTCT service providers in our communities?
• If, yes, can you please tell us who they are, what particular MNCH/PMTCT services they provide, and where they are based/operate?
• If we were to set up a community day family health camp/outreach, in which parish would you like us to set it up in, and why?
• How can we best mobilize the community to attend the community day camp?
• What other services would you like provided on that day?
• Which day of the week would you recommend the community day be run?

Under the **Male and Female Peer Groups intervention**, male and female groups with ten to fifteen members will be established to create an opportunity for them to share their experiences, share coping strategies, learn new knowledge, jointly problem-solve, and positively influence each other with support from a trained facilitator of the same gender.

Therefore we would like to know how we can best mobilize and form these groups:

• Where can we easily mobilize men/female group members?
• Which community members can easily help us mobilize male/female group members
• If meeting a men only/female only group ask which days are better for group member to meet?
Introduction

I. Target /Who the SOPs are intended for

The Standard Operating Procedures (SOPs) are intended to provide guidance on the implementation, monitoring and evaluation of activities to engage community leaders in the EMTCT effort. Specifically these SOPs target:

1. Community Officers
2. Strategic Information and Evaluation Officers
3. Research Officers
4. Data Collectors

II. Purpose/Objectives of the SOPs

The purpose of these SOPs is to provide standardized guidance for day-to-day implementation of the community leader engagement intervention (hereafter referred to as collective action). The objectives are to:
a. Provide a comprehensive outline of roles and responsibilities necessary in implementing the intervention.
b. Provide guidance on carrying out training activities.
c. Provide guidance on providing mentorship and routine supportive supervision activities.
d. Provide guidance on data management for community leaders involved in the intervention.
e. Provide guidance on data management for office staff.

III. How the SOPs should be used
These SOPs should address recruitment, training, supportive supervision, assessment and data collection for the implementation of the collective action intervention. They should be used along with other implementation resources to ensure that each country team executes the intervention according to the set quality standards. Each country team should adapt the SOPs in line with country data collection strategies, team member roles, and existing country policies realistic to implementation strategies.

I. Definitions of Key Populations
1. **Community leaders** will include formal and informal leaders. Community leaders can include individuals appointed or elected into office for an administrative, political, or executive function (such as a local council); individuals who hold a position of leadership within a regimented social or organizational structure (such as religious institutions, societies or clubs); individuals who, by virtue of their position in traditional society, lead community members (such as chiefs, headmen and village heads); and individuals who may not hold specific leadership positions in the community, but are acknowledged and recognized as influential in their communities.
2. **TOTs** will be EGPAF staff and/or consultants who complete the entire course of the TOT training, demonstrate mastery of the knowledge and approaches and participate in curriculum piloting activities intended to equip them to plan and implement the full four-day community leaders’ workshop.
3. **EGPAF Community Officer** will be existing EGPAF staff who are tasked with ensuring that the technical and logistical support necessary to implement the key interventions is available and coordinated. EGPAF community officers will also be responsible for ensuring full documentation of the intervention and adherence to the standard operating procedures defined for the intervention.
## Process

### Recruit and prepare Community Leaders

<table>
<thead>
<tr>
<th>Activity</th>
<th>Use this SOP</th>
<th>Use these materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish recruitment committee</td>
<td>SOP A0-1</td>
<td>SOP A0-2, SOP A0-3</td>
</tr>
<tr>
<td>Select and recruit Community Leaders</td>
<td>SOP A0-4</td>
<td>Form FA0-4</td>
</tr>
<tr>
<td>Screen and register Community Leaders</td>
<td>SOP A0-5</td>
<td>Form FA0-5-1, FA0-5-2</td>
</tr>
<tr>
<td>Consent Community Leaders</td>
<td>SOP A0-6</td>
<td>Form FA0-6</td>
</tr>
</tbody>
</table>

### Adapt curriculum, train trainers and pilot the curriculum

<table>
<thead>
<tr>
<th>Activity</th>
<th>Use this SOP</th>
<th>Use these materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hold CLI curriculum adaptation workshop</td>
<td>SOP A1</td>
<td>Form 2, Report RA1</td>
</tr>
<tr>
<td>Hold TOT workshop</td>
<td>SOP A2</td>
<td>Form 2, Forms FA2-1, FA2-2, Report RA2</td>
</tr>
<tr>
<td>Pilot CLI curriculum</td>
<td>SOP A3</td>
<td>Form 2, Form FA3-1, Report RA3</td>
</tr>
<tr>
<td>Finalize CLI Curriculum</td>
<td></td>
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</tr>
</tbody>
</table>

### Roll-out the intervention

<table>
<thead>
<tr>
<th>Activity</th>
<th>Use this SOP</th>
<th>Use these materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hold CLI</td>
<td>SOP A4</td>
<td>Form 2, Form FA4-1, Report RA4</td>
</tr>
<tr>
<td>Start on-going CL support</td>
<td>SOP A5</td>
<td>Forms FA5-1, FA5-2, FA5-3</td>
</tr>
<tr>
<td>Hold CL Forum</td>
<td>SOP A6</td>
<td>Form 2, Report RA6</td>
</tr>
<tr>
<td>Develop Community Action Plan</td>
<td>SOP A7</td>
<td>Form FA7-1, FA7-2</td>
</tr>
<tr>
<td>Document and disseminate COP</td>
<td>SOP A8</td>
<td>Form FA8-1</td>
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SOP A0-1: Roles and Responsibilities of the EGPAF Staff

1. Purpose

The purpose of this SOP is to provide overall guidance on the roles and responsibilities of the [EGPAF community officer] when supporting the community leaders’ intervention.

2. Roles and Responsibilities of [EGPAF Staff]

1. Recruit Trainers – The [EGPAF community officer] will participate in the briefing and training of trainers.

2. Provide guidance on the recruitment of community leaders and ensure that the recruitment process adheres to the highest standards of transparency, equity and fairness.

3. Participate in the recruitment interviews for community leaders.

4. Arrange logistics for trainers to conduct the pilot testing of the community leaders’ workshop (e.g. transport, copies of questionnaires, allowances, visibility material and protective clothing).

5. Arrange logistics for trainers to conduct the community leaders’ workshop (e.g. transport, venue, copies of participant tools, copies of questionnaires, allowances, incentives, and visibility material).

6. Ensure trainers adhere to training targets, training schedule and the SOPs in general.

7. Ensure that the trainers have all the equipment (audio-visuals, etc.) and supplies (copies of forms, notebooks, participant materials, etc.) that they need for the workshops.

8. Resolve operational and technical challenges faced by trainers.

9. File all project documents (e.g. workshop reports, participant feedback forms, community action plans, mentorship reports, etc.).

10. Ensure that mentorship and support activities are conducted in accordance with the SOPs.

11. Compile and share progress reports with management.

12. Take responsibility for the effective flow of communication and information between trainers, between trainers and the project bureau and between trainers and participants.

13. Report any significant challenges, including actions that compromise the integrity of the participants or actions that compromise the integrity of the intervention that
arise during the course of training and/or mentorship. These should be reported to the community officer and technical director within 24 hours.

14. Provide support and supervision during training and ensure that all the requisite forms and reports are complete and correctly filed.

3. Procedures
   1. Report status in the field to the community officer routinely (at least weekly).
      a. Document planned and completed activities in the field in an email to the community officer.
      b. Outline achievements, challenges and steps taken in order to address challenges.

   2. Conduct quality checks
      a. Participate in a sample of trainings, meetings and field activities related to the community leader intervention, every month.
      b. Give feedback to the trainers in the field to address participant concerns, rising challenges and constraints.
      c. Respond to trainers’ requests, concerns and observations based on guidance from the community officer and country leadership.
      d. Working with the operations research team, review evaluation and routine data collection tools to ensure completeness, accuracy, timeliness and validity of data submitted to the country office.
      e. Ensure that the SI&E officer adheres to the SOPs regarding data management, in order to ensure that project data is routinely available for decision making.
      f. Review key metrics of implementation performance on a monthly basis and flag issues for the attention of the trainers and SI&E leads.

3. Ensure that all procurements and cash requests for field participants are completed on a timely basis.
   a. Compile a list of all materials that will be needed during training, and ensure availability prior to training.
   b. Ensure that participant incentives are readily available and distributed in a timely manner.

4. Support the team in resolving problems occurring in the field.

4. Resources
   1. SOP A0-2: Roles and Responsibilities of Trainers
   2. Appendix A: Checklist of intervention Materials
I. **Purpose**

   The purpose of this SOP is to provide overall guidance on the roles and responsibilities of the trainers and community leader mentors for the community leader intervention.

II. **Roles and Responsibilities of the Trainers and Mentors**

   1. Plan and facilitate workshops to equip community leaders to carry out their activities.

   2. Plan and implement a catch-up provision for community leaders who miss part or all of the trainings.

   3. Plan and facilitate refresher trainings for community leaders based on their identified areas of need.

   4. Ensure that a mentorship and supportive supervision plan is in place for all trained leaders.

   5. Implement the mentorship and supportive supervision plan for all trained leaders (including attending community events, community schemes, providing refresher training, routine phone calls, courtesy calls, etc.).

   6. Plan and facilitate the monthly forums of the community leaders.

   7. Support community leaders to engage in the other project interventions (for the arms that will have two or three interventions).

   8. Maintain confidentiality of information shared by community leaders.

   9. Respond to inquiries regarding the intervention as requested by the relevant country staff.

   10. Communicate as need arises and on a regular basis with the [EGPAF Community Officer] (at agreed upon intervals) to report back on implementation, any challenges that may arise and the need for additional support and supplies.

   11. Ensure that all meeting, training and supportive supervision reports are turned in on a timely basis.

   12. Mentor participants on the documentation of their activities using diaries and ensure that participants receive support in order to adhere to project documentation standards.

   13. Ensure that participant feedback on training and supportive supervision processes is synthesized and fed into planning for future activities such as refresher trainings, regular forum meetings and supportive supervision activities.

III. **Procedures**

   1. Trainers will report to the [EGPAF Community Officer].
2. Regular meetings will be held after each event to debrief the implementing or supervising team and at routine intervals (daily or weekly) to give feedback to the community officer on progress.

3. Trainers will submit the following forms and reports to the community officer and/or [EGPAF Community Officer] after completing these key events:
   a. Form 2: Workshop Attendance Register
   b. Form FA4-1: Participant Evaluation CL Training
   c. Form FA5-1: Mentorship Plan
   d. Form FA5-3: Community Leaders’ Diary Abstraction
   e. Report RA6: Community Leaders’ Forum Report Template
   f. Form FA7-1: The CAP Template

IV. Resources

1. SOP A0-3: Roles and Responsibilities of Community Leaders
2. SOP A7: Developing the CAP
3. Appendix A: Checklist of Implementation Materials
SOP A0-3: Roles and Responsibilities of Community Leaders

I. Purpose

The purpose of this SOP is to provide overall guidance on the roles and responsibilities of the community leaders.

II. Roles and Responsibilities of the Community Leaders

Relationship building. Members of the community action team (trained leaders and other community leaders in the community who will be supporting them to implement the different activities) will be expected to vigorously pursue and drive collaboration between and across key stakeholders and organizations in the community, including those who have not traditionally seen safe motherhood and elimination of pediatric HIV as core issues within their mandate. This might include: holding courtesy calls with elected, designated and administrative officials, etc.

Persuasion. Utilizing deep knowledge of the community’s health profile, members of the community action team will play a key role in persuading a wide variety of individuals, stakeholders and organizations to prioritize safe motherhood and the elimination of pediatric HIV. This might include: holding courtesy calls, lobbying elected officials, lobbying administrators, advocacy activities, writing letters, petitions and formal requests, attending public budget review meetings, providing citizen feedback, etc. to solicit commitment to action on the part of elected officials and administrators.

Raising visibility. Members of the community action team will utilize their existing leadership roles to build a platform for increased awareness and visibility of the possible solutions that communities can find and implement in order to solve the challenge of maternal mortality and pediatric HIV. This might include: holding events, local campaigns, giving public testimony and creating platforms for local champions and advocates to discuss the relevant issues.

Community planning. Members of the community action team will work with other key stakeholders and leaders in their communities to develop culturally relevant strategies and solutions to the challenge of maternal mortality and pediatric HIV in their communities, building on their understanding of the key gaps, challenges and barriers that their communities face. This might include:

Aligning resources and people. Drawing upon their familiarity with the local context, their reputation and influence, members of the community action team will be expected to identify key players and potential resources and create the conditions to capitalize on these in order to achieve healthy outcomes for all mothers and babies. This might include: identifying the key stakeholders on specific issues; identifying partners who are already engaged in actions to address key issues identified at community level; generating agreement from local officials to support selected community priorities; organizing agreement between local organizations to provide technical support for community actions, etc.

Building consensus. The members of the community action team will be expected to deploy conflict resolution and negotiation skills to promote agreement and consensus on the critical path towards achieving a neutral and non-partisan maternal and child survival agenda, working
with and through the various stakeholders in their local communities, including those who may not ordinarily find common ground for collaboration.

**Fostering community ownership.** The members of the community action team will be expected to extensively engage and involve communities in generating a shared vision for health and understanding of the critical actions that must be supported by individuals, families, peers, networks, and social groups. *This might include: holding public discussions to identify consensus points on MNCH and health issues; soliciting community voluntarism for specific local projects; soliciting community contributions (financial and in-kind) for specific actions.*

**Mobilizing for collective action.** Leveraging their positions of influence and authority, community action team members will work with individuals and groups to drive change through concrete, high-impact actions and projects that galvanize a wide base of ordinary citizens towards a common cause. *This might include: generating local projects to address key needs of communities; holding public brainstorming meetings to identify local actions that are within the capacity of communities to implement and sustain; using traditional authorities and structures to address social norms.*

**Maximizing community assets.** The community action team will identify and leverage existing structures, processes, resources and opportunities to support concrete action at community level.

### III. Procedures

1. Community leaders will document their interactions with community members and other leadership in the community diary, which will be submitted to the [EGPAF Community Officer] either monthly or quarterly, for data abstraction.

2. Community leaders will disseminate information on the key MNCH and health gaps and barriers widely within their communities. They will consult extensively with members of their communities on actions that redress these and will incorporate all viewpoints into a feasible community action plan that addresses the local context.

3. Community leaders will submit to the [the EGPAF Community Officer] the draft and the final updated/revised versions of the community action plans.

4. Regular meetings will be held (initially monthly and quarterly thereafter) to share experiences, challenges, breakthroughs and lessons learned with each other and with [the EGPAF Community Officer] and/or Community Focal Person.

5. Regular updates will be provided through phone calls and individual meetings with [the EGPAF Community Officer].

### IV. Resources

1. Form FA5-2: Community Leaders’ Diary
2. SOP A7: Developing the Community Action Plan
3. Form FA7-1: Template for CAP
4. SOP A8: Documenting CAP revisions
5. Form FA7-1: CAP Status Update Form
SOP A0-4: Community Leader Selection and Recruitment

a. **Purpose**
   The purpose of this SOP is to provide guidance on the participant recruitment process for the community leader intervention.

b. **Roles and Responsibilities**
   1. [EGPAF Community Officer] will ensure that:
      a. Recruitment procedures are well understood within the project clusters.
      b. An (informal) recruitment committee comprised of health facility staff, district health management teams (DHMT) members, community leaders, key informants and EGPAF personnel is appointed.
      c. Recruitment is transparent, balanced, participatory, representative, fair and follows the processes detailed in the procedures section of this document.
      d. Recruitment is supervised.
      e. Recruitment is thoroughly documented and that Form FA0-5-1, the Community Leader Registration Log, is completed and collected before the committee disbands.
   2. A recruitment committee comprised of one representative from the DHMT, administrative arm, community health committee (or where there is none, the Village Health Team), community leaders and the PLWHA constituency will be convened.

   The Recruitment Committee will ensure that:
      a. The selection criteria specified for participants are strictly adhered to throughout the recruitment process.
      b. The nomination schedule or deadline is observed.
      c. The recruitment process is thoroughly documented, in accordance with the processes detailed in the procedures section of this document.
      d. Selected participants are duly notified.
      e. All inquiries from the community are responded to within 48 - 72 hours.
      f. Communication with the EGPAF team is continuous and timely.

c. **Procedures**
   1. EGPAF Community Officer] will notify the relevant offices (official offices and stakeholder entities) of intent to commence recruitment at least one month before the recruitment process is scheduled to commence.
   2. In each cluster, [EGPAF Community Officer] will constitute a recruitment committee to oversee participant selection and will notify members of the proposed working schedule, scope of work, and timelines as early as possible.
   3. [EGPAF Community Officer] will be present at every meeting of the recruitment committee.
4. [EGPAF Community Officer], working with the recruitment committee should develop and agree to a plan to nominate potential participants for the community leader intervention. This will include:
   a. Identifying critical institutions, communities, and individuals to be involved in the community leader intervention.
   b. Target leaders with authority to make decisions and the power to mobilize e.g. (Zimbabwe – Village Heads, Uganda – Parish Chiefs and Swaziland- Bucopho and Inner Council Members) etc.
   a. Identifying key contact persons within the key institutions who can attest to individual character and suitability of persons selected as participants.
   b. Identifying local leaders within geographic locations who can attest to the individual character and suitability of persons selected as participants.

2. The recruitment committee should generate a list of all people who are judged to meet the selection criteria and work with the recruitment committee to contact key persons that can confirm the ability of these individuals to represent their constituencies and their communities.

3. The recruitment committee should develop a timeline for individually contacting identified individuals, to document their availability and interest in participation.

4. A master list of all nominated persons, institutional or neighborhood support, confirmation of interest to participate and contact information (Form FA0-4 Community Leader recruitment register) should be generated before the recruitment committee disbands.

   d. Resources
   1. Form FA0-4 Community Leader recruitment register.
SOP A0-5: Community Leader Screening and Registration

I. Purpose
The purpose of this SOP is to provide guidance on the screening and registration process for the community leader intervention.

II. Roles and Responsibilities
1. EGPAF Staff will ensure that:
   a. The completed recruitment register (Form FA0-4) must be returned to EGPAF and the information recorded.
   b. Each nominated person is screened again for eligibility by the Project Staff.
   c. Participants on the recruitment log should be contacted and confirmed on their availability and interest and then entered by name into Form FA0-5-1, the Community Leader Screening and Enrollment Log.
   d. Participants are appropriately informed of key dates and priorities.
   e. Contact information for participants who confirm their availability is collected and stored.
   f. Only participants on the final selection list are registered and receive their information packages.

III. Procedures
5. Final selected participants should be informed of a range of dates and times where they can be formally briefed for participation in the intervention.

6. [EGPAF Community Officer] will lead the registration and briefing process.

7. After the community leader has indicated interest and willingness to be in the project and met the inclusion criteria of being:
   a. A current resident of the area
   b. Resident in the area for not less than two (2) years

8. The explanation of the project task should include the purpose, what is being requested of the participant, the procedures (what will happen to him/her), what risks he/she may face as a result of participating, what benefits he/she may gain. Explain that participation is completely voluntary and that he/she will not lose any services he/she normally gets from the clinic if he/she decides not to participate.

9. Give him/her enough time to understand the project and what is being asked of him/her. Encourage him/her to ask questions. This process can take place in a group.

10. When the participant indicates that he/she is ready to make a decision (making sure that it is without undue influence), have him/her sign the registration forms. If the participant is not willing to join the project thank him/her and indicate that he/she is free to leave.
11. If he/she is willing to join the project he/she should sign and date a registration form. He/she needs to sign and date the form in ink, and not in pencil. It should be clear that joining the project is voluntary.

12. If the participant cannot read and write, he/she should place an “X” in the signature area.

13. You will need to sign and date the registration form as well. You will place the original in a file folder, which you will need to keep. A participant may decide to withdraw from the project at any time. In this case, you will notify the supervisor who will then complete a Project Termination Form and file it together with the original registration form.

14. The registration forms will be stored for three years and should be available for audit after the end of the Project.

IV. Resources
   2. Form FA0-4: Community Leader Recruitment Register
   3. Form FA0-5-1: Community Leader Screening and Enrolment Log
   4. Form FA0-5-2: Community Leader Registration form
   5. Appendix C: CL information Package
I. Purpose

The workshop will undergo a first and second level technical review to ensure that the curriculum design addresses the intervention objectives, and ensure that it is appropriate to the target audience in each country. In addition, the curriculum will undergo a structured adaptation process to ensure that its content is appropriate to local context.

The purpose of the adaptation workshop will be to:

- Ensure that the workshops methods proposed in the curriculum adhere to best practices in adult education.
- Ensure that the curriculum meets the information needs of the target audience.
- Ensure that the scenarios and examples referenced in the curriculum are culturally appropriate.
- Ensure that the illustrations, case studies, ice-breakers and small group activities specified in the curriculum are easy to follow and appropriate for the target audience.
- Ensure that the language utilized in the curriculum is appropriate for a wide range of literacy levels.
- Ensure that the trainers are able to complete a simulation of the community leaders’ workshop in an environment that approximates the implementation conditions.
- Ensure that the technical content in the curriculum is modulated to the audience’s stage of behavior adoption, and relevant to their span of influence.

The purpose of this SOP is to provide guidance on the adaptation process for the Community Leaders’ Manual curriculum.

II. Roles and Responsibilities

1. (EGPAF Community Officer) will ensure that:
   a. The logistics for the two-day adaptation workshop are appropriately planned (venue is secured; the workshop materials and supplies are available, audio-visual aids, etc.)
   b. External reviewers with expertise in training and/or supervising community cadres are identified and invited for the workshop.
   c. Participants receive the workshop materials in electronic format at least one week prior to the adaptation workshop.
   d. Key resources for the adaptation workshop are made available. Local staff who will participate in the adaptation workshop (the TOTs and any other technical advisors) are duly notified.
e. Presenters are duly notified of their responsibilities, and presentations are made available

f. A report of the adaptation workshop is compiled and disseminated

2. The participants will ensure that:
   a. They have skimmed through the draft curriculum before the adaptation workshop commences
   b. They follow up on the action plans and next steps (for those selected to complete the final curriculum edits)

III. Procedures
1. The working session will open with an overview of EGPAF and the community engagement strategy. It will include an overview of the community leaders’ intervention and a key summary of findings from the community entry process in the respective country.

2. The participants will undertake a walk-through of the curriculum, including the key methods and content and discuss any preliminary feedback participants have on amending the key themes and approaches.

3. The participants should undertake a group walk-through of each technical content module (sessions on gender, stigma, sexual health, maternal and child health, and eMTCT), reviewing the appropriateness of the objectives.

4. After the group walk-through, participants should break into small groups to discuss, reviewing:
   a. The comprehensiveness of the content
   b. Language and appropriateness
   c. Pacing of the content
   d. Time allotted to the technical content (in relation to the entire training)

5. Participants should present their small group feedback in plenary, with time for general discussion (to build consensus).

6. After completion of each of the technical modules, the recommended edits and changes should be clearly summarized by the group, including persons responsible and realistic timelines.

7. A report of the adaptation workshop should be compiled.

8. A small team from the country Project should be identified to work with the facilitators to complete a detailed work through of the curriculum revisions immediately after the workshop.

IV. Resources
1. Form 2: Workshop attendance register
2. Report RA1: Report template for the adaptation workshop
I. Purpose
The purpose of the TOT workshop will be to provide the key staff who will implement the community leaders’ workshop, the supportive supervision and mentorship, with the following:

- An overview of the CLE process, including the conceptual underpinnings, history, different models and justification for approach.
- A review of the roles and responsibilities of the project team in the CLE process.
- A discussion of adult/participatory learning methodology and the specific needs and challenges of working with the specified audience.
- A detailed review of the CLE process, including a thorough review of the SOPs
- A detailed review of the workshop preparation process including how to prepare the site, etc.
- A detailed review of the workshop materials and methodology.
- A detailed review of the mentorship materials and methodology.
- A discussion and review of the tools, resources and activities to complement the training package.
- A plan for workshop logistics and the development of the agenda.

II. Roles and Responsibilities
1. (EGPAF Community Officer) will ensure that:
   a. The logistics for the TOT workshop are appropriately planned (venue is secured; the workshop materials and supplies are available, e.g. audio-visual aids, etc.).
   b. Key resources for the TOT workshop are available.
   c. Local staff who will participate in the adaptation workshop (the TOTs and any other technical advisors) are duly notified.
   d. Key note speakers and presenters are duly notified of their responsibilities and presentations are made available.

III. Procedures
1. The planning team should develop and agree to a robust training schedule and logistics agenda for the TOT trainings, including:
   a. Dates and times for conducting the TOT
   b. Petty cash and procurement logistics
   c. Supplies and materials

2. The host team should designate one person to take a lead role in the trainings as a co-facilitator.
3. Not less than three weeks prior to the specific workshop, the host team should discuss/review with the co-facilitators:
   a. The detailed agenda for the five day workshop
   b. Designating the logistics focal point (who will work on venue finalization, transportation details, refreshments and meals, lodging, etc.)
   c. Designating the communications focal point (to work on notifying the relevant stakeholders and participants ahead of time)
   d. Assigning responsibilities for documentation and report writing
   e. Plans to invite guest speakers, guests of honor, key stakeholders, etc.
   f. The participant list for the TOT training

4. Prior to the workshop, workshop materials and supplies should be prepared, as listed in the workshop planning checklist.

5. Each participant should receive, no less than two weeks prior to the workshop, a needs assessment for completion.

6. On opening day, the training team should observe the following:
   a. Ensure that every participant is fully registered
   b. Start the workshop with introductions of all participants and facilitators
   c. Develop ground rules for the workshop

7. During the workshop, the training team should observe the following:
   a. Arrive at the workshop early enough to set up the room.
   b. Ensure that the room is organized in one of two sitting arrangements: either a complete circle with no head or small tables that fit six to eight participants.
   c. Assign a timekeeper and rule monitor for the day.
   d. Each TOT should follow the curriculum as closely as possible.
   e. A ‘parking lot’ should be generated during each session and revisited at the end of each session and day.
   f. Notes should be taken paying particular attention to participants’ insights, shared experience, concerns, questions, action plans, and priorities.

9. At the end of each day, the training team should allot 30 minutes to 1 hour to debrief the issues of the day, with a keen eye on:
   a. Content that participants have difficulty grasping or accepting
10. On the last day of the workshop, the training team should observe the following:
   a. Clear next steps from the EGPAF team are communicated to participants.
   b. Clear next steps from the participants are shared with each other and the EGPAF team.
   c. Participants should agree to a monthly meeting schedule for the next quarter.

11. The training team should schedule and hold a debriefing meeting no more than 24 – 48 hours after the workshop has been completed. The debriefing meeting should review:
   a. Participants who require intensive coaching on basic concepts beyond what their peers might require.
   b. Participants who require catch up sessions due to missed workshop or missed sessions.
   c. Participants who will require intensive coaching during the community action planning.
   d. Successful innovations, ad libs, breakthrough moments, etc.
   e. Sessions of the curriculum that should be prioritized for piloting including conducting a dialogue.

12. A detailed workshop report should be completed by the training team, using the workshop report template.
   a. Distribution list for the workshop report should be established and observed.
   b. The internal approvals process prior to distribution should be established and observed.
   c. The final workshop report should be available for internal distribution (within EGPAF) no later than three business days after the workshop.
   d. The final workshop report should be available for external distribution (to key stakeholders) no later than one month after the workshop.

IV. Resources
   1. Form 2: Workshop attendance register
   2. Form FA2-1: Learning Needs Assessment Form
   4. Community Leaders’ Manual TOT Package
SOP A3: Piloting the Community Leaders Manual

I. Purpose

The purpose of this SOP is to provide guidance on the piloting process for the Community Leaders’ Manual. The workshop curriculum will undergo a first and second level technical review to ensure that the curriculum design addresses the intervention objectives and that it is appropriate to the target audience in each country. In addition, the curriculum will be piloted by the trainers who will facilitate the community leader workshops.

1. The purpose of the pilot exercise will be to:
   a. Ensure that essential elements of the curriculum are pre-tested with the target audience in an environment that approximates the implementation conditions.
   b. Ensure that the trainers are able to complete a simulation of the community leaders’ workshop in an environment that approximates the implementation conditions.

II. Roles and Responsibilities

1. EGPAF Staff will ensure that:
   a. The logistics for the two-day pilot are appropriately planned.
   b. Community leaders participating in the pilot are appropriately selected and screened.
   c. Community leaders that are participating in the pilot are fully apprised of the purpose and intention of the pilot.
   d. Participant feedback is thoroughly documented and processed.
   e. Feedback from participants is utilized to refine the adapted manual.

1. The TOTs will ensure that:
   a. The sections of the community leaders’ manual curriculum that will be piloted for are faithfully executed.
   b. All issues encountered during the piloting of the community leaders’ manual are fully documented.
   c. All participant evaluations are completed as required.

All notes for peer feedback are completed as required

II. Procedures

1. [EGPAF Staff] will select a site for the pilot based on a thorough consideration of the logistical and financial implications of operating within the site.

2. Selection of the pilot cluster should be negotiated in close coordination with the cognizant Regional/District authorities and implementing partners (as appropriate), and take into consideration, the relevant protocols.

Selecting participants when piloting outside the EGPAF clusters

3. Working with the main EGPAF project, [EGPAF Staff] should identify and recruit for participation in this pilot, a group of leaders likely to have similar
demographic factors, influence, and educational status as specified in the community leader selection criteria.

4. Care should be taken to ensure that women and youth are represented amongst the participants.

5. No more than eight to twelve participants should be selected to take part in each pilot, in order to ensure that the participants have the opportunity to provide extensive feedback.

6. [EGPAF Staff] will ensure that all logistics, including venue, participant list and contact information, refreshments and meals, workshop materials, participant forms, transportation refunds and participant compensation are adequately catered for.

7. [EGPAF Staff] will ensure that all participants receive formal communication on the purpose and intents of the pilot exercise.

Selecting participants when piloting within the EGPAF clusters

8. [EGPAF Community Officer] should identify and recruit a group of leaders who have some experience in supporting either health or social projects as champions, advocates, project staff, or trainers. This group of leaders should ideally have some insight into the pre-testing or pilot process and why it is important; they should also have familiarity working with the target audience for the community leader workshops.

9. Care should be taken to ensure that women and youth are represented amongst the participants.

10. No more than eight to twelve participants should be selected to take part in the pilot, to ensure that all participants have the opportunity to provide extensive detail.

11. [EGPAF Staff] will ensure that all logistics, including venue, participant list and contact information, refreshments and meals, workshop materials, participant forms, transportation refunds and participant compensation are adequately catered for.

12. [EGPAF Staff] will ensure that all participants receive formal communication on the purpose and intents of the pilot exercise.

Conducting the pilot exercise

13. The TOTs will lead the pilot effort in pairs or in triplets; at least one member of the project management team (ideally either the Community Officer or the Technical Director) must be present.
14. The TOTs will ensure that at a minimum, the following aspects of the Community Leaders’ Manual are simulated as part of the pilot:

   a. Overview/explanation of the intervention
   b. Presentation of health outcomes based on facility data
   c. Stakeholder analysis/social mapping
   d. Developing the community action plan
   e. Review of the Diary

15. Additional segments of the workshop may be identified for addition to the pilot, based on trainers’ feedback after the TOT.

16. The supervising EGPAF staff (i.e. Community Officer) will take detailed notes on the following:

   a. TOT’s mastery of the content and approach
   b. TOT’s skillful facilitation of the participants
   c. Appropriateness of the sequence of the material in the curriculum
   d. Key questions asked by participants, including those that indicate resistance, difficulty grasping the material, limited time allotted in schedule, etc.
   e. Contentious or controversial issues
   f. Profile of participants who grasp and/or embrace material
   g. Profile of participants who struggle with and/or reject material

17. After completion of each session of the pilot, the TOTs should ensure that:

   a. Key questions have been documented.
   b. Community leaders’ have the opportunity to probe the issues that lack clarity and resolution.
   c. Community leaders’ knowledge is probed through skillfully guided conversational tactics.
   d. The points requiring clarity and resolution are carefully documented.

18. After completion of the entire pilot, each participant should be required to complete a training evaluation. The TOTs and other EGPAF staff should thoroughly review each evaluation for completion.
19. After completion of the pilot, the trainers should be given adequate time to compile brief notes on their peer-feedback.

20. The entire pilot team should generate a brief report with details of the session and key action items, utilizing the workshop report outline.

III. Resources
1. Form 2: Workshop Attendance Register
2. Report RA3: Pilot Workshop Report Template
3. Community Leaders’ Manual Training Package
SOP A4: Implementing the Community Leaders Manual

I. Purpose
The purpose of this SOP is to provide guidance on facilitating the Community Leaders’ Manual.

II. Roles and Responsibilities
1. EGPAF Staff will ensure that:
   a. The logistics for the four-day workshop are appropriately catered for.
   b. A detailed training calendar is developed, with specific dates, locations, times and persons assigned to each.
   c. A full team comprised of two to three TOTs and a data collector is assembled and prepared for the four-day workshop.

2. The TOTs will ensure that:
   a. The manual for the community leaders’ is faithfully executed.
   b. All issues encountered during the implementation of the community leaders’ manual are fully documented.
   c. A detailed agenda and logistics plan for each day’s activities is discussed with the entire training team, including data collection.
   d. Adequate workshop materials and supplies are prepared for each workshop.
   e. Adequate accommodations are made for participants requiring deeper explanations.

3. The project staff will ensure that:
   a. The registration forms are completely and accurately filled.
   b. The workshop evaluations and attendance registers are completed as required.

III. Procedures
1. The [EGPAF Staff] should develop and agree to a robust training schedule and logistics agenda for rolling out the community leaders’ manual, including:
   a. Dates and times for conducting the workshops by cluster
   b. Transportation logistics
   c. Petty cash and procurement logistics
   d. Training team and data collection assignments
   e. A communication plan to notify district/regional/ward authorities of plans
   f. A communication plan to notify participants of workshop plans
2. The members of the training team (comprised of two or three TOTs and EGPAF Staff) should be notified of their workshop assignments.

3. Not less than three weeks prior to the specific workshop, the training team should hold a planning meeting to refine and discuss:
   
   a. The detailed agenda for the four day workshop.
   
   b. Designating the logistics focal point (who will work on venue finalization, transportation details, refreshments and meals, lodging, etc.).
   
   c. Designating the communications focal point (to work on notifying the relevant stakeholders and participants ahead of time)/
   
   d. Assigning responsibilities for documentation and report writing.
   
   e. Plans to invite guest speakers, guests of honor, key stakeholders, etc.

4. Each participant should be notified of the workshop schedule by phone call, letter or SMS not less than two weeks prior to the workshop.
   
   a. Participants who can confirm their participation on the slated dates should be noted.
   
   b. Future workshop dates should be communicated to participants who indicate a schedule conflict and their commitment to participate in a future workshop should be secured.

5. Prior to the workshop, workshop materials and supplies should be prepared, as listed in the workshop planning checklist.

6. On opening day, the training team should observe the following:
   
   a. Ensure that every participant is fully registered.
   
   b. Ensure each participant has completed the KAPB before the workshop starts.
   
   c. Start the workshop with introductions of all participants and facilitators.
   
   d. Develop ground rules for the workshop.

7. During the workshop, the training team should observe the following:
   
   a. Arrive at the workshop early enough to set up the room.
   
   b. Ensure that the room is organized in one of two sitting arrangements; a complete circle with no head or small tables that will fit six to eight participants.
   
   c. Assign a timekeeper and rule monitor for the day.
d. Each TOT should follow the curriculum as closely as possible.

e. A ‘parking lot’ should be generated during each session and revisited at the end of each session and day.

f. Notes should be taken with particular attention paid to participants’ insights, shared experience, concerns, questions, action plans and priorities.

8. At the end of each day, the training team should allot thirty minutes to one hour to debrief the issues of the day, with a keen eye on:

   a. Content that participants have difficulty grasping or accepting
   b. Adjustments to the schedule
   c. Particularly successful or difficult sessions
   d. Participants who might require further training and coaching on basic concepts

9. On the last day of the workshop, the training team should observe the following:

   a. Clear next steps from the EGPAF team are communicated to participants.
   b. Clear next steps from the participants are shared with each other and the EGPAF team.
   c. Ensure that all participants receive their certificates and incentives.
   d. Participants agree to a monthly meeting schedule for the next quarter.

10. Participants who missed the workshop should be contacted at the end of each workshop day.

   a. Participants who missed the first day should be contacted. Confirmation of intent to continue participation should be established, and those confirming their intention to participate in the intervention should be reminded to attend the subsequent sessions.
   b. Participants who miss any of the subsequent days should be contacted at the end of each day.
   c. Participants who miss substantial segments of the workshop should indicate their preferences for catch up sessions.

11. The training team should schedule and hold a debriefing meeting no more than 24 – 48 hours after the workshop has been completed. The debriefing meeting should review:

   a. Participants who require intensive coaching on basic concepts beyond what their peers might require.
b. Participants who require catch up sessions due to missed workshops or sessions.

c. Participants who will require intensive coaching during the community action planning.

d. Successful innovations, ad libs, breakthrough moments, etc.

12. A detailed workshop report should be completed by the training team, using the workshop report template.

   a. Distribution list for the workshop report should be established and observed.

   b. The internal approvals process prior to distribution should be established and observed.

   c. The final workshop report should be available for internal distribution (within EGPAF) no later than 3 business days after the workshop.

   d. The final workshop report should be available for external distribution (to key stakeholders) no later than 1 month after the workshop.

IV. Resources

1. Form 1: Workshop Planning Checklist
2. Form 2: Workshop Attendance Register
3. Form FA0-5-2: Community Leader Registration Form
4. KAPB-lite for Community Leaders
5. Form FA4-1: Participant Evaluation of CLI
6. Form FA5-2: Community leaders’ diary
7. SOP A7: Process and procedures for completing the Community Action Plan
8. Form FA7-1: Template for CAP
9. Certificates of completion
10. Community Leaders’ Manual TOT Package
SOP A5: Providing Ongoing Support to the Community Leaders

I. Purpose
The purpose of this SOP is to provide guidance on providing ongoing support (virtual and in-person) to the trained Community Leaders. This will include developing a mentorship and support plan, based on the information shared by community leaders during regularly scheduled one-on-one meetings, community leaders’ forums, and reviewing and abstracting the information in the community leader diaries.

II. Roles and Responsibilities
1. The [EGPAF staff] will ensure that:
   a. The community profile is updated and available for identifying technical resources and key activities in each cluster.
   b. A routine mentorship and support plan is developed and maintained for each community leader.
   c. Each community leader receives the routine mentorship and support detailed in their plan.
   d. Routine mentorship and support activities are reviewed with each community leader at least twice a year.

III. Procedures
1. In the community leaders’ manual, the TOTs should ensure that each community leader has documented the specific technical, non-financial, supports and skills needed for conducting dialogues to develop and implement a community action plan in his/her cluster(s).

2. Upon completion of the community leaders’ manual, the TOTs should ensure that the [EGPAF Staff] and community leaders’ commit to a scheduled one-hour block for one-to-one discussion of the routine mentorship and support needs especially on conducting dialogues.
   a. The first of these should ideally occur not more than three weeks after the manual.
   b. EGPAF teams may explore a variety of modalities to deliver these one-to-one discussions, including in-person, by phone, and linked to team or implementation activities.
   c. These one-to-one discussions should be scheduled at least twice yearly.

3. After the community leaders’ manual and prior to the development of the routine mentorship and support plans, the EGPAF team should make the following preparations:
a. The entire EGPAF team, including the training teams, should meet to discuss the routine support requested by the community leaders.

b. The entire EGPAF team should determine the routine support requests that are within the technical and physical capacity of the existing team to meet and:

   o Identify who within the EGPAF technical team is able to meet these requests.
   o Plan on how the trained leaders will be supported with skills to conduct dialogues in their communities.
   o Identify the time frame within which the identified resource persons can meet these requests.
   o Document this as a technical support menu.

c. The entire EGPAF team should determine the routine support requests that are not within the technical or physical capacity of the existing team to meet but can be met by the organs of government.

   o Identify which government organ (RHMTs, DHMTs, health facility staff, etc.) has the mandate, capacity and ability to meet these requests.
   o Discuss and clarify the role that EGPAF should play in linking or referring the community leaders to these organs.
   o Discuss and clarify the role that the community leaders should play in actively seeking this support.
   o Document this in the technical support menu.

d. The entire EGPAF team should determine the routine support requests that are not within the technical or physical capacity of the existing team to meet, but can be met by other implementing partners or corporations.

   o Identify which implementing partner (NGOs, CBOs, associations, corporations etc.) has the capacity and ability to meet these requests.
   o Discuss and clarify the role that EGPAF should play in linking or referring the community leaders to these institutions.
   o Discuss and clarify the role that the community leaders should play in actively seeking this support.
   o Document this in the technical support menu.

e. The entire EGPAF team should determine the routine support requests that are not within the technical or physical capacity of the existing team to
meet and cannot be met by any other offices, entities, implementing partners or corporations.

- Document this in the technical support menu.

4. Prior to the scheduled one-to-one discussion, the EGPAF team should develop a clear plan that assigns EGPAF staff (or volunteers or consultants) to each community leader or each group of community leaders.

5. Prior to the scheduled one-to-one discussion, a technical support menu should be developed.

6. Prior to the scheduled one-to-one discussion, a response to each leader’s specific support requests should be prepared.

7. During the scheduled one-to-one discussions:
   a. Each leaders’ specific, non-monetary supports for completing and implementing the community action plan should be discussed.
   b. Realistic time frames for response by the EGPAF staff should be discussed based on local context, complexity of the request, and capacity of the leader.
   c. The [EGPAF Staff] and community leader should come to some agreement on realistic supportive actions the EGPAF staff can take (examples of which are reflected below in item 4 of this SOP).
   d. The [EGPAF Staff] and community leader should come to some agreement on an ideal time within approximately six months to follow up on the routine support arrangement.

8. The outcomes of this one-to-one discussion should be documented in Form A4-1: the mentorship plan.

9. The [EGPAF Staff] responsible should meet after all the mentorship plans have been developed to debrief on these, and secure approval from the project leadership.

10. On a monthly basis, the [EGPAF Staff] responsible should complete Form AX-G (the mentorship report), with updates on the mentorship process. These should be reviewed during the monthly EGPAF project meetings.

11. Throughout the year, the EGPAF team should jointly review mentorship plans against the mentorship report, data from the community leader diaries and the minutes of the Community Leaders’ Forums, to ensure that support needs are proactively identified and addressed.

IV. Resources
I. Purpose
The community leaders will meet every month for the first quarter after training and quarterly thereafter. These meetings will be important platforms for providing refresher training, routine technical updates, reflecting on shared experiences, discussing breakthrough opportunities, peer sharing and facilitated exchange. The purpose of this SOP is to provide guidance on planning and facilitating the Community Leaders’ Forum.

II. Roles and Responsibilities
1. EGPAF staff will ensure that:
   a. The logistics for the half-day workshop are appropriately catered for.
   b. Participants, guests and key stakeholders are given advance notice of the forum dates and venue.

III. Procedures
1. A half-day community leaders’ forum will be organized and conducted every month for the first quarter after the initial community leaders’ manual workshop and every quarter subsequent to this.

2. For the initial quarter after training, the community leaders’ forum should be closed only to the trained participants, to allow the EGPAF team sufficient time to work on team dynamics, capacity building, and technical support.

3. Special attention should be given to developing community dialogue skills of communities as they will be using these skills to get information to develop their community action plans.
   a. After the first quarter of monthly meetings, the community leaders’ forum may be opened up to key resource persons and liaisons from key structures, as long as these have the potential to facilitate the work of the community leaders.
   b. External resource persons or stakeholders who may be invited to participate in the community leaders’ forums include the VHT, community health committee, other community leaders, DHMT, RHMT, CSO Forum, etc.
   c. However, the inclusion of external resource persons or stakeholders should be purposeful, targeted and serve a clear purpose, aim or function, that is
aligned with helping community leaders develop and/or implement their CAPs.

4. The [EGPAF staff] should develop and agree to an agenda and logistics plan for the community leaders’ forum, including:
   a. Dates and times for conducting the workshops by cluster
   b. Transportation logistics
   c. Petty cash and procurement logistics
   d. Training team and data collection assignments
   e. A communication plan to notify district/regional/ward authorities of plans
   f. A communication plan to notify participants of forum plans

5. The member(s) of the EGPAF team responsible for facilitation should be assigned. Ideally and, if possible, the facilitation team should be consistent in order to build rapport and ensure team cohesiveness.

6. Not less than one week prior to the specific forum, the facilitator(s) should refine and discuss:
   a. The detailed agenda for the half-day forum
   b. The logistics plan (venue finalization, transportation details, refreshments and meals, lodging, etc.)
   c. The communications plan (notifying the relevant stakeholders and participants ahead of time, etc.)
   d. Assigning responsibilities for documentation and report writing
   e. Plans to invite guest speakers, guests of honor, key stakeholders, external facilitators, etc.

7. Each participant (including key speakers, guests, external resource persons, trainers, etc.) should be notified of the workshop schedule by email, phone call, or SMS not less than one week prior to the forum.

8. Prior to the meeting, materials and supplies should be prepared, as listed in the forum preparation checklist.

9. The facilitator(s) team should observe the following:
   a. Ensure that every participant is fully registered
   b. Follow the detailed agenda faithfully
   c. End each meeting with clear priorities for objectives, topics and an agenda for the next forum
10. Though the agenda for each meeting will be determined by participants’ needs and preferences, at a minimum, each forum should incorporate the following:

   a. Community leader updates on progress soliciting input for the development of the CAP.
   
   b. Community leader updates on their progress drafting, disseminating, implementing and reviewing the CAPs.
   
   c. Challenges, lessons learnt and best practices for implementing their CAPs.

11. At the end of each day, the facilitators team should allot 30 minutes to one hour to debrief the issues of the day, ensuring that the following is observed:

   a. Clear next steps from the EGPAF team are communicated to participants.
   
   b. Clear next steps from the participants are shared with each other and the EGPAF team.
   
   c. Ensure that all participants receive any incentives as stipulated and approved in the country work plan and budget.
   
   d. Participants agree to objectives, agenda items, and priorities for the next meeting.

12. Participants who missed the meeting should be contacted at the end of each day to:

   a. Confirm their intent to continue with participation.
   
   b. Arrange alternatives to brief and update those confirming their intention to participate in the intervention in the future.
   
   c. Remind community leaders who miss any of the forums to attend subsequent sessions and provide them with the meeting schedule.
   
   d. Complete the project termination form (Form 5) for community leaders who indicated that they will be unable to continue to participate in the intervention.

13. A detailed meeting report should be completed by the facilitator(s), using form RA-6, the meeting report template.

   a. Distribution list for the meeting report should be established and observed.
   
   b. The final meeting report should be available for internal and external distribution (to key stakeholders) no later than 1 week after the forum.

IV. **Resources**

1. **Form 2: Workshop Attendance Register**
SOP A7: Developing the Community Action Plan

I. Purpose
A community action plan will be produced for each of the participating communities. Each community action plan will reflect the MNCH, PMTCT and health needs prioritized by communities, through a process of facilitated dialogue. The CAPs should be completed in the local language.
The purpose of this SOP is to provide guidance to EGPAF staff on the Community Action Plan (CAP) development process, which will be explained in detail to participants at the Community Leaders Manual, and deliberated during the Community Leaders’ Forums.

II. Roles and Responsibilities
1. [EGPAF Staff] will ensure that:
   a. Community leaders are making adequate progress towards the development of the action plans.
   b. Community leaders report routinely on progress towards developing their action plans.
2. The TOTs will ensure that:
   a. During the Community Leaders Manual training, all partners understand the process for developing the CAPs.
   b. In the Community Leaders Manual, all participants demonstrate understanding of the CAP as a living document.

III. Procedures
1. During the Community Leaders Manual, [EGPAF staff] will ensure that all participants thoroughly brainstorm the actions, audiences, stakeholders, and processes necessary to develop a realistic and wholly community-owned action plan. This should include at the minimum:
   a. Planned meetings to solicit support and involvement within each leader’s key constituency
   b. Planned meetings to solicit the support and involvement of key stakeholders within the defined geographic boundaries (including health staff, civil society, marginalized groups and key constituencies)
   c. Planned meetings to discuss the health priorities of their communities and generate ideas and concrete actions to follow up on these
   d. Plans to use major events, venues, and gatherings to disseminate EMTCT, MNCH and family health planning information
   e. Plans to participate in other EGPAF interventions and activities
2. During the first quarter after their training, the community leaders will be expected to conduct dialogues in their communities that create awareness and come up with challenges, solutions and timeframes on MCH /PMTCT.

3. Before the first quarterly community leaders’ forum, community leaders will be expected to share the list of ideas generated in their communities for discussion, debate and prioritization, resulting in the first draft of the community action plan.

4. At the first quarterly community leaders’ forum, the first draft of the community action plan will be shared with their peers for critique, refinement and prioritization.

5. Community leaders should produce one community action plan per cluster by combining all the CAPs from the different villages. They need to rank all the common challenges highlighted by each leader that are common and develop the cluster CAP.

6. After the first quarterly community leaders’ forum, the community leaders will be expected to widely share the draft cluster CAP for broad review across constituencies and stakeholders in their communities. Key opportunities for this could include:
   a. EGPAF community days
   b. Ongoing health campaigns
   c. Celebrations, festivals and holiday observances
   d. Religious gatherings
   e. Civil society forums, meetings, gatherings, etc.

7. After broad dissemination of the draft community action plans, community leaders should synthesize all feedback, critique and commitments, for use in refining the CAPs.

8. Finalized CAPs will be presented at the next community leaders’ quarterly forum.

9. Progress on the CAPs will be tracked by the community leaders in Form FA7-3 - Community Leaders’ Diary and reported at each community leaders’ quarterly forum.

IV. Resources
1. Form FA7-1: Template for CAP
2. Form FA5-1: Community Leaders’ Diary
3. Form FA5-2: Community Leaders’ Diary abstraction form
SOP A8: Documenting the CAP Completion and Revisions

I. Purpose
The purpose of this SOP is to provide guidance to the EGPAF team on documenting the CAP completion.

II. Roles and Responsibilities
1. EGPAF staff will ensure that:
   a. Community leaders submit all completed CAPs to the EGPAF team.
   b. Community leaders submit any updates to the CAPs to the EGPAF team.

III. Procedures
1. At each community leaders' forum, leaders will be asked to share with their peers updates on the development, dissemination, implementation, and revision of their cluster CAPs.
2. Community leaders will be expected to complete their CAPs in triplicate upon completion, revision or review, so that:
   a. One copy is filed with the EGPAF team
   b. One copy is retained with the community leader(s) responsible
   c. One copy is maintained in a file on collective action within the community
3. EGPAF staff will revise the draft cluster CAPs and give feedback to the trained leaders. The leaders will incorporate the feedback and submit the final CAPs to EGPAF staff who will ensure that all CAPs are translated into English.
4. Upon completion, revision or review, the copy maintained for filing with the EGPAF team will be issued a unique identifying number or code.
5. Upon completion of each quarterly community leaders’ forum, the [EGPAF staff] will be required to complete form FA7-1 - the CAP status update form and fill in:
   a. The cluster name
   b. Cluster ID
   c. Date initially completed
   d. Date reviewed and revised
   e. Status of implementation (initiated, completed, suspended)
   f. Challenges
   g. Lessons learned
6. The [EGPAF Staff] will reach out to participants who miss a community leaders’ forum to organize a drop-off point or meeting to submit their CAPs as soon as possible.

IV. Resources
1. Form FA8-1: CAP Status Update Form
Introduction

I. Purpose/Objectives of the SOP

The purpose of this SOP is to provide a clear process on how the EGPAF model of the community leaders institute will be adapted and implemented.

The objectives are to provide guidance:

f. The necessary processes to adapt the material to the country context.

g. The selection of the trainers to conduct the Community Leaders Institute.

h. Selecting the community leaders or organization members who will participate.

i. Conducting training, mentorship and supportive supervision for the community leaders.

j. Documentation of advocacy activities by community leaders, and data collection and management by EGPAF staff.

II. Why Community Leadership Engagement

By augmenting facility-based PMTCT interventions and scaling-up with a bold plan for the community buy-in and demand generation, EGPAF hopes to establish a sustainable and more effective package of interventions that not only addresses gaps in the health system, but links closely to priorities spelled out in the Global Plan for Elimination of Pediatric HIV/AIDS.

III. What is the Community Leaders Institute?

In order to achieve the 90-90-90 targets by 2020, innovative strategies in service delivery have to be employed. Strengthening of CBOs, engaging community leadership and faith based leaders in addressing stigma as well as ensuring robust and adaptable “differentiated” models of service delivery within the health system itself is critical. To achieve the first “90” strategic community engagement will ensure acceptability of enhanced provider initiated testing, alongside community based testing interventions.

1. The Community Leaders Institute (CLI) is a five to ten day training package that seeks to:

   a. Equip community leaders from various sub-sections of the population to:
      
      • Understand and increase ownership and control of health activities in their communities.
      
      • Pursue and drive collaboration between and across key stakeholders and organizations in the community to achieve universal ART access.
      
      • Leverage their positions of influence and authority, and work with individuals and groups to drive change through concrete, high-impact actions and projects and enhance communities
understanding of MCH, HIV testing, PMTCT and accessing ARV treatment.

- Create opportunities for discussion, to enable the target communities to come together for reflective dialogue to build critical awareness of health seeking behavior by dispelling myths and misconceptions around MCH, PMTCT, HIV testing. Community leaders will enhance community understanding of the benefits of ARV treatment thereby enhancing the health outcomes of mothers, children and families as a whole.
- Identify bottlenecks and challenges to MCH, HIV testing and universal treatment and come up with solutions to solve these, drawing upon their familiarity with the local context and their reputation and influence.

IV. Technical Assistance Required for Implementation

It is recommended that a member of the global team or another country team who is experienced in this methodology be engaged to support the country team when this is first taken on. The optimal time allocation would be two weeks for preparation, two to three weeks in country, and two weeks for periodic follow up with the in-country team.

V. Procedures

1. Adaptation of the Community Leaders Institute (CLI) curriculum- The curriculum will undergo a structured adaptation process to ensure that its content is appropriate to local context.

   a. The EGPAF team should engage a small group of the appropriate stakeholders in a review of the curriculum. This should include a global team member (or someone experienced in teaching the CLI), and could also include EGPAF staff, community representatives, MOH or others.

   b. The original materials are geared towards MCH and PMTCT messaging. The materials, community leader diaries, dialogue guides and Community Action Plan templates should be adapted to focus on the precise desired outcomes for the country.

   c. Once the draft CLI is completed, it should undergo a technical review at EGPAF to ensure that the curriculum design addresses the intervention objectives and EGPAF technical guidance requirements and that it is appropriate to the target audience in the country.

   d. The adaptation workshop should then be held to gain consensus in country with a wider group of stakeholders to ensure that:

      - The curriculum meets the information needs of the target audience.
      - The scenarios and examples referenced in the curriculum are culturally appropriate.
The illustrations, case studies, ice-breakers and small group activities specified in the curriculum are easy to follow, and appropriate for the target audience.

- The language utilized in the curriculum is appropriate for a wide range of literacy levels.
- The messaging is clear and appropriate for the country context, including all national policies and guidelines.

2. Each community or organization participating in this intervention will have to recruit the community leaders. In each community, an (informal) recruitment committee comprised of health facility staff, district health management teams (DHMT) or Ward Health Committees, community leaders and EGPAF personnel can be appointed.

   a. The committee will recruit leaders that have influence (leaders that are listened to by the community and that command followership) and have the power to mobilize communities for community meetings. Leaders who do not meet this selection criterion should not be selected as they will find challenges in enforcing the different requirements and needs of this intervention.

   b. Recruitment should be transparent, balanced, participatory, representative and fair.

3. **Training of trainer’s workshop** - The purpose of the TOT workshop will be to provide key staff who will implement the community leaders’ workshop with supportive supervision and mentorship skills, to discuss adult/participatory learning methodology required by community leaders, including community dialogue and advocacy skills, to address the specific needs and challenges of working with the specified audience and to do a thorough review of the SOPs, tools, resources and activities to complement the training package. Again, someone with experience in the CLI should lead this exercise.

4. **Community leaders training** - The EGPAF team should develop and agree on a training schedule and logistics agenda for rolling out the CLI, including, dates and times for conducting the workshops, training team members and creating the communication plan to notify district/regional/ward authorities and participants of the of the training workshop.

   a. The training should be done over five to ten days to ensure that the leaders understand the concepts, practice conducting, pilot the training and develop the community action plans (each community action plan will reflect the needs prioritized by communities, through a process of facilitated dialogue).

5. EGPAF staff will have to develop a robust mentorship and support plan. This plan should be implemented as soon as the community leaders go back to their
respective communities. This is based on the gaps observed during community leaders training, CAPs documentation (it usually takes time for community leaders to grasp how to complete their diaries), and other needs as noted in the scheduled one-on-one meetings, community leaders’ forums, and reviewing and abstracting the information in the community leader diaries.

6. **Community Leaders Forum** - EGPAF staff will provide mentorship to the community leaders, meeting with community leaders every month for the first quarter, and quarterly thereafter. These meetings will be important platforms for providing refresher training and routine technical updates, reflecting on shared experiences, discussing breakthrough opportunities, peer sharing and facilitated exchange.

7. **Documentation and Data Management** - EGPAF staff will be given skills to support community leaders in data collection using diaries for the meetings they will conduct in the community. They will also abstract this information and report it on a monthly basis to show the progress and impact of the intervention through qualitative weekly reports and quantitative monthly reports.
Community Leader Forms

Annex A. Intervention Materials

The following forms are used in these SOPs and are included in a separate file:

- Form 1: Workshop Preparation Checklist
- Form 2: Workshop Attendance Register
- Project Termination
- Form FA0-4: Community Leader Recruitment Register
- Form FA0-5-1: Community Leader Screening and Enrolment Log
- Form FA0-5-2: Community Leader Registration Form
  - Report RA1: Adaptation Workshop Report Template
- Form FA2-1: Learning Needs Assessment Form
- Form FA2-2: Community Leaders’ Participant evaluations
  - Report RA2: TOT Workshop Planning Checklist
- Form FA3-2: Participant Evaluation of the CL Manual Pilot
- Form FA4-1: Participant Evaluation Community Leaders Manual
- Form FA5-1: Mentorship Plan/Technical Support Menu
  - Report RA5: Mentorship Report
- Form FA5-2: Community Leader Diary
- Form FA5-3: Community Leaders’ Diary Abstraction
  - Report RA6: Quarterly Forum Meeting Report Template
- Form FA7-1: CAP Template
- Form FA7-2: CAP Status Report
- Form FA7-3: Community Leaders’ Diary

The following materials are available to support implementation:
• Community Leaders’ Manual Adaptation workshop materials and tools
• TOT workshop materials and tools
• Pilot materials and tools
FAO-4: Participant Recruitment Register

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Recruitment Committee Members:

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<th>Last Name</th>
<th>First Name</th>
<th>Sex</th>
<th>Title (Mr/Mrs/Miss/Hon/Dr/Prof)</th>
<th>Resident more than 2 years in area? (Y/N)</th>
<th>Fluent in local language? (Y/N)</th>
<th>Have a current or past leadership role in community? (Y/N)</th>
<th>Experience working with different organizations?</th>
<th>Constituency Type (Fill: women, youth, religious sector, PLWHA, CBO, political sector or other)</th>
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</tbody>
</table>
Form 5: Termination of Study Form

Staff Name: ____________________________________________
Staff ID: _____________________________________________

Date completed (dd/mm/yyyy): [__ __] [__ __] [__ __ __ __]

Community Number: ______________________
Participant ID: ______________________

Reason for withdrawal/termination:
______________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________

Applicable to trained facilitators ONLY

I attest that I am withdrawing participation from this study on good terms. All financial or in-kind obligations promised by the project have been honoured. I am owed no financial or in-kind remuneration for the voluntary work I have done on behalf of my community.

Date: ____________________
Participant Signature: ____________________
## Form FA05-1 Community Leader Screening and Enrolment Log

<table>
<thead>
<tr>
<th>Community Name</th>
<th>Community Number</th>
<th>Staff Name</th>
<th>Staff ID</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Screening Criteria met?</th>
<th>Participant Enrolled?</th>
<th>If not enrolled, Reason</th>
<th>Date Consent Obtained (dd/mm/yyyy)</th>
<th>Copy of consent to participant</th>
<th>Date Consent Obtained (dd/mm/yyyy)</th>
<th>CL ID (Given CL-ID)</th>
<th>Information package given</th>
<th>Date Participant Terminated (dd/mm/yyyy)</th>
<th>Reason (Withdrawn, Lost to follow up, or other)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Yes</td>
<td></td>
<td>Yes</td>
<td>_ _ _ _ _</td>
<td>Yes</td>
<td>_ _ _ _ _ _</td>
<td>Yes</td>
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<td></td>
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<tr>
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<td>_ _ _ _ _</td>
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<td>_ _ _ _ _</td>
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<td>_ _ _ _ _ _</td>
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</table>
Form FA05-2: Community Leader Registration Form

Participant Register for Community Leaders

<table>
<thead>
<tr>
<th>District/Region Name:</th>
<th>STUDY NUMBER ___ ___ - ___ ___</th>
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<tbody>
<tr>
<td></td>
<td>Cluster - ID Number</td>
</tr>
<tr>
<td>Community Name:</td>
<td>Form filled in by:_____________</td>
</tr>
<tr>
<td></td>
<td>Print name</td>
</tr>
</tbody>
</table>
| Community Number:    | Staff ID:_____________________
|                      | Date: __ __ - __ __ - 20 __ __ |
|                      | Day - Month - Year            |

DEMOGRAPHIC INFORMATION

<table>
<thead>
<tr>
<th>Informed consent signed</th>
<th>0 No (do not continue until informed consent is signed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Yes</td>
</tr>
</tbody>
</table>

| Last Name               |                                                         |
| First Name              |                                                         |

Age (in completed years)

Address (please write directions or map on back of page)

Village of residence

Mobile Phone/s

BACKGROUND AND INSTITUTIONAL INFORMATION

<table>
<thead>
<tr>
<th>Designation</th>
<th>1</th>
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<tr>
<td></td>
<td>Formal Leader</td>
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<tr>
<td></td>
<td>Informal Leader</td>
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</table>

<table>
<thead>
<tr>
<th>Title</th>
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<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>Mr</td>
<td>Mr</td>
<td>Mr</td>
<td>Mr</td>
</tr>
<tr>
<td>Miss</td>
<td>Miss</td>
<td>Miss</td>
<td>Miss</td>
</tr>
<tr>
<td>Mrs</td>
<td>Mrs</td>
<td>Mrs</td>
<td>Mrs</td>
</tr>
<tr>
<td>Position</td>
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<tr>
<td>----------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Traditional Leader</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political Leader/Elected representative</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious Leader</td>
<td>3</td>
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<td>Civil Society Leader</td>
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<td>Civil Servant</td>
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<tr>
<td>Women’s Leader</td>
<td>6</td>
<td></td>
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<tr>
<td>Youth Representative</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media Representative</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business/Private Sector Leader</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No position</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td>99</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Name of Institution**

**Address of Institution**

Last name (printed): _____________________________

First name (printed): _____________________________

Signature: _____________________________
Deliberations – Summary of key content highlighting participant contributions during following segments
- Overview of the project
- Review of the formative assessment and survey results
- Overview of the conceptual approach of the intervention and workshop curriculum
- High-level walk through of the curriculum content
- In-depth review of the curriculum content

Key Recommendations – Summary of necessary edits to ensure
- Cultural relevance (local sayings, cultural practices, traditional institutions, etc.)
- Appropriateness of the language
- Health system, political structures and social organization is accurately reflected
- Responsiveness to community priorities (from formative research)
- Appropriate pacing of the material
- Appropriate scope of the material
- Appropriate balance between practice, brainstorming and lectures
- Relevance of handouts

Next Steps
- Follow up items
- Persons responsible
- Timelines

List of participants
- Names
- Position/Title
- Institution
Form FA2-1: Community Leaders’ Manual TOT Workshop Learning Needs Assessment

Thank you for registering for the Community Leaders’ Manual TOT Workshop to be held in [name of town] in [month]. We are excited about sharing the EGPAF methodology and curriculum for engaging community leaders to mobilize social action, and preparing you to roll out these trainings in the intervention communities.

To help us design the TOT workshop so it best meets your needs, please respond to the following questions and send this back by [DATE].

1. Your Name:

2. Position:

3. Indicate if you have attended trainings, workshops, or technical updates on any of the following in the past (select all):
   a. Behavior change communications
   b. Sexual prevention of HIV and AIDS
   c. Peer education/peer learning methodologies
   d. Prevention of mother to child transmission of HIV/AIDS
   e. Adult learning methodologies
   f. Monitoring and evaluation
   g. Conflict resolution and negotiation
   h. Advocacy and communications

4. Have you conducted trainings for adult lay audiences in the past? Y/N

5. Do you have any supervision, project planning, and/or project management experience? Y/N

6. Which specific issues would you like the workshop to focus on?

7. How much experience do you have working with the target audience of the Community Leaders’ Manuals?

8. Please share your expectations for this workshop.

9. Please share any specific learning objectives for this workshop.
Deliberations – Summary of key content highlighting participant contributions during following segments

- Overview of the project
- Review of the formative assessment and survey results
- Overview of the conceptual approach of the intervention and workshop curriculum
- High-level walk through of the curriculum content
- In-depth review of the curriculum content

Key Recommendations – Summary of necessary edits to ensure

- Cultural relevance (local sayings, cultural practices, traditional institutions, etc.)
- Appropriateness of the language
- Health system, political structures and social organization is accurately reflected
- Responsiveness to community priorities (from formative research)
- Appropriate pacing of the material
- Appropriate scope of the material
- Appropriate balance between practice, brainstorming and lectures
- Relevance of handouts

Next Steps

- Follow up items
- Persons responsible
- Timelines

List of participants

- Names
- Position/Title
- Institution
# FA3-1: Community Leaders Manual Pilot Participant Evaluation

<table>
<thead>
<tr>
<th>Facilities</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. How would you rate the overall quality of the space?</td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>(1)</td>
</tr>
<tr>
<td>Good</td>
<td>(2)</td>
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<tr>
<td>Fair</td>
<td>(3)</td>
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<tr>
<td>Poor</td>
<td>(4)</td>
</tr>
<tr>
<td>Very poor</td>
<td>(5)</td>
</tr>
<tr>
<td>2. Was there enough physical space for participants to work comfortably?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>(1)</td>
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<tr>
<td>No</td>
<td>(2)</td>
</tr>
<tr>
<td>3. How would you rate the comfort facilities at this venue?</td>
<td></td>
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<tr>
<td>Very comfortable</td>
<td>(1)</td>
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<tr>
<td>Comfortable</td>
<td>(2)</td>
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<tr>
<td>Fair</td>
<td>(3)</td>
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<tr>
<td>Uncomfortable</td>
<td>(4)</td>
</tr>
<tr>
<td>Very uncomfortable</td>
<td>(5)</td>
</tr>
<tr>
<td>4. How would you rate the dining facilities at this venue?</td>
<td></td>
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<tr>
<td>Very good</td>
<td>(1)</td>
</tr>
<tr>
<td>Good</td>
<td>(2)</td>
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<tr>
<td>Fair</td>
<td>(3)</td>
</tr>
<tr>
<td>Poor</td>
<td>(4)</td>
</tr>
<tr>
<td>Very poor</td>
<td>(5)</td>
</tr>
<tr>
<td>5. How would you rate the audio-visual facilities at this venue?</td>
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<tr>
<td>Very good</td>
<td>(1)</td>
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<tr>
<td>Good</td>
<td>(2)</td>
</tr>
<tr>
<td>Fair</td>
<td>(3)</td>
</tr>
<tr>
<td>Poor</td>
<td>(4)</td>
</tr>
<tr>
<td>Very poor</td>
<td>(5)</td>
</tr>
<tr>
<td>6. How would you rate the accommodation at this venue (skip if training is non-residential)?</td>
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<tr>
<td>dimension</td>
<td>rating</td>
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<td>-------------------</td>
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</tr>
<tr>
<td>Organization</td>
<td></td>
</tr>
<tr>
<td>7. How would you rate the project team's organization?</td>
<td></td>
</tr>
<tr>
<td>Very organized</td>
<td>☐ (1)</td>
</tr>
<tr>
<td>Organized</td>
<td>☐ (2)</td>
</tr>
<tr>
<td>Fair</td>
<td>☐ (3)</td>
</tr>
<tr>
<td>Unorganized</td>
<td>☐ (4)</td>
</tr>
<tr>
<td>Very unorganized</td>
<td>☐ (5)</td>
</tr>
<tr>
<td>8. How would you rate the project team’s communication?</td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>☐ (1)</td>
</tr>
<tr>
<td>Good</td>
<td>☐ (2)</td>
</tr>
<tr>
<td>Fair</td>
<td>☐ (3)</td>
</tr>
<tr>
<td>Poor</td>
<td>☐ (4)</td>
</tr>
<tr>
<td>Very poor</td>
<td>☐ (5)</td>
</tr>
<tr>
<td>9. Were expectations, norms and rules clarified prior to starting the workshop?</td>
<td>☐ (1)</td>
</tr>
<tr>
<td>No</td>
<td>☐ (2)</td>
</tr>
<tr>
<td>10. Were participants given an opportunity to introduce themselves and to know the facilitation team?</td>
<td>☐ (1)</td>
</tr>
<tr>
<td>Yes</td>
<td>☐ (1)</td>
</tr>
<tr>
<td>No</td>
<td>☐ (2)</td>
</tr>
<tr>
<td>Materials and supplies</td>
<td></td>
</tr>
<tr>
<td>11. How would you rate the quality of hand-outs and participant manuals?</td>
<td>☐ (1)</td>
</tr>
<tr>
<td>Very good</td>
<td>☐ (1)</td>
</tr>
<tr>
<td>Good</td>
<td>☐ (2)</td>
</tr>
<tr>
<td>Poor</td>
<td>☐ (3)</td>
</tr>
<tr>
<td>Very poor</td>
<td>☐ (5)</td>
</tr>
<tr>
<td>12. How would you rate the adequacy of supplies for participants?</td>
<td>☐ (1)</td>
</tr>
<tr>
<td>Very good</td>
<td>☐ (1)</td>
</tr>
<tr>
<td>Good</td>
<td>☐ (2)</td>
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<tr>
<td>Fair</td>
<td>☐ (3)</td>
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<tr>
<td>Poor</td>
<td>☐ (4)</td>
</tr>
<tr>
<td>Very poor</td>
<td>☐ (5)</td>
</tr>
</tbody>
</table>
Appropriateness of the workshop content
13. How would you rate the appropriateness of the topics covered in this workshop?

- Very appropriate □ (1)
- Appropriate □ (2)
- Inappropriate □ (3)
- Very inappropriate □ (4)

14. How would you rate the instructions for the exercises, ice breakers and small group sessions?

- Very appropriate □ (1)
- Appropriate □ (2)
- Inappropriate □ (3)
- Very inappropriate □ (4)

15. How would you rate the appropriateness of the exercises, ice breakers and small group sessions?

- Very appropriate □ (1)
- Appropriate □ (2)
- Inappropriate □ (3)
- Very inappropriate □ (4)

16. How would you rate the flow or sequence of topics in the curriculum?

- Very appropriate □ (1)
- Appropriate □ (2)
- Inappropriate □ (3)
- Very inappropriate □ (4)

Time
17. How would you rate overall time management for this workshop?

- Very good □ (1)
- Good □ (2)
- Fair □ (3)
- Poor □ (4)
- Very poor □ (5)

18. Was the time allotted enough to cover each session sufficiently?

- Yes □ (1)
- No □ (2)

19. Was there sufficient time for the breaks throughout the day?

- Yes □ (1)
- No □ (2)

20. Was there enough time for participant interaction, sharing and small group sessions?

- Yes □ (1)
- No □ (2)
21. Was there enough time for questions to be asked and answered?
   
   Yes □ (1)
   No □ (2)

Facilitators
22. Were there enough facilitators for the workshop?
   
   Yes □ (1)
   No □ (2)

Follow up plans
23. Was there sufficient time for participants to discuss follow up plans?
   
   Yes □ (1)
   No □ (2)

Suggestions
24. What topics could be added to the workshop content to enhance participant learning?

_____________________________________________________________________________________

25. What topics could be removed from the workshop content without diminishing participant learning?

_____________________________________________________________________________________

26. Which topics were difficult for you to explain or deliver?

_____________________________________________________________________________________

27. Which topics were difficult for the participants to understand or conceptualize?

_____________________________________________________________________________________

28. What issues or topics would you like further training on? (reading materials, etc.)

_____________________________________________________________________________________

29. Do you have any other suggestions for improving the curriculum and handouts?

_____________________________________________________________________________________

Report RA3: CLI Pilot Meeting Report Template

Cover page (Country, authors, venue, dates)
Table of contents
Workshop Objectives
Workshop Agenda

Workshop Facilitators

Opening Remarks

Deliberations – Summary of key content highlighting participant contributions during following segments
- Overview of the project
- Review of the formative assessment and survey results
- Overview of the conceptual approach of the intervention and workshop curriculum
- High-level walk through of the curriculum content
- In-depth review of the curriculum content

Key Recommendations – Summary of necessary edits to ensure
- Cultural relevance (local sayings, cultural practices, traditional institutions, etc.)
- Appropriateness of the language
- Health system, political structures and social organization is accurately reflected
- Responsiveness to community priorities (from formative research)
- Appropriate pacing of the material
- Appropriate scope of the material
- Appropriate balance between practice, brainstorming and lectures
- Relevance of handouts

Next Steps
- Follow up items
- Persons responsible
- Timelines

List of participants
- Names
- Position/Title
- Institution
# Evaluation of Community Leaders’ Training

<table>
<thead>
<tr>
<th>District/Region Name:</th>
<th>Date: ___ ___ - ___ ___ - ___ ___</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Day – Month – Year</td>
</tr>
<tr>
<td>Community Name:</td>
<td>Venue:</td>
</tr>
</tbody>
</table>

## Facilities

1. How would you rate the overall quality of the space?
   - Very good [ ] (1)
   - Good [ ] (2)
   - Poor [ ] (3)
   - Very poor [ ] (4)

2. Was there enough physical space for participants to be comfortable?
   - Yes [ ] (1)
   - No [ ] (2)

3. How would you rate the comfort facilities at this venue?
   - Very comfortable [ ] (1)
   - Comfortable [ ] (2)
   - Uncomfortable [ ] (3)
   - Very uncomfortable [ ] (4)

4. How would you rate the dining facilities at this venue?
   - Very good [ ] (1)
   - Good [ ] (2)
   - Poor [ ] (3)
   - Very poor [ ] (4)

5. How would you rate the audio-visual facilities at this venue?
   - Very good [ ] (1)
   - Good [ ] (2)
   - Poor [ ] (3)
   - Very poor [ ] (4)
Organization

6. How would you rate the project team’s organization?
   - Very organized [ ] (1)
   - Organized [ ] (2)
   - Disorganized [ ] (3)
   - Very disorganized [ ] (4)

7. How would you rate the project team’s communication?
   - Very good [ ] (1)
   - Good [ ] (2)
   - Poor [ ] (3)
   - Very poor [ ] (4)

8. Were expectations, norms and rules clarified prior to starting the workshop?
   - Yes [ ] (1)
   - No [ ] (2)

9. Were participants given an opportunity to introduce themselves and to know the facilitation team?
   - Yes [ ] (1)
   - No [ ] (2)

Materials and supplies

10. How would you rate the quality of hand-outs and participant manuals?
    - Very good [ ] (1)
    - Good [ ] (2)
    - Poor [ ] (3)
    - Very poor [ ] (4)

11. How would you rate the adequacy of supplies for participants?
    - Very good [ ] (1)
    - Good [ ] (2)
    - Poor [ ] (3)
    - Very poor [ ] (4)

Appropriateness of the content of the workshop

12. How would you rate the appropriateness of the topics covered in this workshop (just right, insufficient, too much material)
    - Very appropriate [ ] (1)
    - Appropriate [ ] (2)
    - Inappropriate [ ] (3)
    - Very inappropriate [ ] (4)
13. How would you rate the appropriateness of the exercises, ice breakers and small group sessions? (just right, etc.)

   Very appropriate   □ (1)
   Appropriate        □ (2)
   Inappropriate      □ (3)
   Very inappropriate □ (4)

**Time**

14. How would you rate overall time management for this workshop?

   Very good          □ (1)
   Good               □ (2)
   Poor               □ (3)
   Very poor          □ (4)

15. Was the time allotted to cover each session sufficient?

   Yes                □ (1)
   No                 □ (2)

16. Did the workshop start punctually as scheduled?

   Yes                □ (1)
   No                 □ (2)

17. Was there sufficient time for the breaks throughout the day?

   Yes                □ (1)
   No                 □ (2)

18. Was there enough time for participant interactions, sharing and small group sessions?

   Yes                □ (1)
   No                 □ (2)

19. Was there enough time for questions to be asked and answered?

   Yes                □ (1)
   No                 □ (2)

**Facilitators**

20. How would you rate the facilitation team for this workshop?

   Very good          □ (1)
   Good               □ (2)
   Poor               □ (3)
   Very poor          □ (4)

21. Were there enough facilitators for the workshop?
22. Were the facilitators skilled and knowledgeable?
   Yes [ ] (1)
   No [ ] (2)

23. Did the facilitators routinely check to ensure that the workshop meets your expectations?
   Yes [ ] (1)
   No [ ] (2)

**Follow up plans**

24. Did you have sufficient time to discuss follow up plans?
   Yes [ ] (1)
   No [ ] (2)

25. Were the follow up plans for you as an individual clear?
   Yes [ ] (1)
   No [ ] (2)

26. Were the follow up actions for the facilitation/project team clear?
   Yes [ ] (1)
   No [ ] (2)

**Suggestions**

27. One thing to change about the workshop.

_____________________________________________________________________________________

28. One thing to remove from the workshop.

_____________________________________________________________________________________

29. What is one thing you liked about this workshop?

_____________________________________________________________________________________

30. Do you have any other thoughts?

_____________________________________________________________________________________
Form RA4: Community Leaders’ Manual Workshop Report Template

Cover page (Community/Community Name, venue, dates)
Table of contents
Workshop Objectives
Workshop Agenda
Workshop Facilitators
Opening Remarks
Deliberations
  Summary of discussions
  Questions and answer summary
Breakthrough opportunities
Challenges
  Technical topics that need revisiting
  Logistical challenges
Next Steps (Participant commitments to the project)
Follow up items (EGPAF staff commitments to participants, with timelines)
  Priorities for refresher trainings
  Mentorship needs
Appendices:
  List of participants
  Summary of workshop evaluations
  Summary of mentorship plans
  Images
# FA5-1 Mentorship Plan/ Technical Support Menu

<table>
<thead>
<tr>
<th>Team Member ID:</th>
<th>Month/Year:</th>
<th>Community Name and ID</th>
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<tbody>
<tr>
<td>Community Leader ID:</td>
<td>CL Last Name:</td>
<td>CL First Name:</td>
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<thead>
<tr>
<th>Issues/Types of support required</th>
<th>Support planned</th>
<th>Date Scheduled</th>
<th>Date Completed</th>
<th>Community Leader Signature</th>
<th>EGPAF Staff Signature</th>
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<thead>
<tr>
<th>Issue Key (options)</th>
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<tbody>
<tr>
<td><strong>Issues to be reinforced</strong></td>
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<tr>
<td>Using community data, identifying key affected population; working with marginalized populations; drafting CAPs; prioritizing actions for the CAP; managing conflict; grassroots advocacy; understanding health issues; understanding the local governance systems; learning PMTCT guidelines; learning MNCH guidelines; learning HIV prevention methods; learning FP methods</td>
</tr>
<tr>
<td><strong>Types of support</strong></td>
</tr>
<tr>
<td>Phone/call; quarterly forum meeting; refresher training; critiquing CAP; attending local events; introductions to other NGOs; linking to national resources; linking with the health system; one-on-one meeting</td>
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</table>
Report RA5-1 Quarterly Mentorship Report

Staff Name: ___________________________________________  Staff ID: ____________  Date completed (dd/mm/yyyy): ________________

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<thead>
<tr>
<th>Community Name/ID</th>
<th>Last Name of Community leader</th>
<th>First Name of Community leader</th>
<th>CL ID</th>
<th>Meeting Date</th>
<th>Meeting Date</th>
<th>Meeting Date</th>
<th>Support Given This Quarter</th>
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*Please record all activities for the month. More pages can be added as needed.*

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<tr>
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<tr>
<td>Activity/Event:</td>
<td>____Advocacy ____CAP Activity ____ EGPAF Activity ____Other: ____________________</td>
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<td>Venue:</td>
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<td>____Advocacy ____CAP Activity ____ EGPAF Activity ____Other: ____________________</td>
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### Record of Community Action

#### New CAP Activities (List all started during this period)

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#### Existing CAP Activities (describe with number participating)

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#### Local legislation

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<thead>
<tr>
<th>Name/Purpose of local by-law</th>
<th>Action</th>
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<tr>
<td>Introduced</td>
<td>Debated</td>
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#### Meetings with EGPAF Staff

#### Successes reported with CAP Activities

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#### Challenges reported with CAP activities and their resolution

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#### Community Feedback on health services

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#### Health Management Feedback on Service Utilization and Improvement Initiatives

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#### Other Activities/Notes/Comments:

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Community Leader’s Diary Abstraction Form

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<td>Advocacy</td>
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<td>Courtesy Calls</td>
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<td>Lobbying governance structures</td>
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<td>Constituency Activities</td>
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<td>Dialogue meetings</td>
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<td>Public speeches and addresses</td>
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<tr>
<td>CAP Plan Implementation</td>
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<td>Local legislation passed</td>
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<td>New activities started</td>
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<tr>
<td>Involvement in EGPAF activities</td>
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<td>Peer Facilitator recruitment committee</td>
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Successes and breakthroughs:

Challenges or issues:

Other comments:
Report RA6: Community Leaders’ Forum (Meeting Report Template)

Cover page (Community/Community Name, venue, dates)
Meeting Facilitators
Table of contents
Meeting Objectives
Meeting Agenda
Opening Remarks
Deliberations
Breakthrough opportunities

Summary of progress on community action plans
  Summary of draft community action plans presented
  Summary of implementation reports from community leaders
  Summary of critique and feedback from peers
  Summary of critique and feedback from meeting facilitators and/or guest speakers
  Challenges reported by community leaders

Next Steps
  Recommendations for the EGPAF staff
  Recommendations for the community leaders

Follow up items and timelines
  Priorities for refresher trainings
  Mentorship needs
  Agenda for the next forum meeting

List of participants
Developing a Plan of Action in your Community

**Community Action Team Work Plan**

**Goals:** The goals of the community leaders include 1) receiving the findings and the recommendations from community members; 2) developing an action plan based on those recommendations; and 3) ensuring that structures are in place to implement the actions. The overall goal of the action plan should be to enhance the health and well-being of women, infants and families in your community by improving the resources and services systems available to them.

**Purpose:** The community leaders comprise two types of members: those who have the political will and fiscal resources to create large-scale systems change and those who can define a community perspective on how best to create the desired change in the community. The process of developing the CAPs should include:

| **Prioritizing recommendations.** | Based on the findings and recommendations presented by the community members and review of vital statistics data, what are the overarching needs present in the community? Are there any needs particular to one or only a few cases that are so pressing they must be addressed at once? |
| **Developing an action plan.** | How can the recommendations be addressed? What organizations have jurisdictions over these issues? What issues are outside the jurisdiction of the entities present? Who else should be involved? |
| **Setting a time frame.** | Action time frames may be short term (less than one year) or long term (more than one year). |
| **Maintaining a work plan for action.** | Each year selected member(s) from the community should volunteer to complete and update the action plans as they develop. |
| **Monitoring progress.** | Community leaders will present progress of implementing actions at each monthly or quarterly community leaders forum/meeting. |
| **Informing the broader community about the need for action and on successes.** | When and how will the larger community be informed of the plan for health improvement and on progress? |
| **Keeping track.** | The action plan should include a mechanism for keeping track of community action projects, to ensure that they are sustained. |
| **Determining if the community’s needs are changing over time and deciding which actions should be added or altered to meet them.** | How do current findings build on past activities? Are the community’s needs changing or are old problems recurring? |

**Interventions and Workplan**

For each community action identified, complete a brief work plan such as the one outlined below. Identify the action steps necessary to effect change, the person or agency that will be responsible for implementing these action steps, the timeline for action, the resources required or needed for action and leave space to document the status of the proposed action at later meetings.

**Community Action Team Worksheet**
<table>
<thead>
<tr>
<th>Key Challenge</th>
<th>Action Steps</th>
<th>Person/Agency Responsible</th>
<th>Time Line</th>
<th>Resources</th>
<th>Status of Proposed Action</th>
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<tbody>
<tr>
<td>Theme: Right to Health</td>
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<tr>
<td>Theme: Stigma and Discrimination</td>
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<td>Theme: Gender (Including male involvement, couples communication on health)</td>
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<tr>
<td>Theme: Family Health</td>
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<tr>
<td>Theme: Reproductive Health</td>
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**Communicating with the Community**

The CAT must document its decisions and successes and bring this information to the wider community on an annual basis. Consider the following questions as you develop a communication plan:

How will team members present the action plan to their constituencies?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

How will the larger community learn about the action plan and CAT successes?
Are there existing community events or forums where information can be shared?

Past Findings and Actions

Finally, think about prior action plans from this team (refer to meeting minutes, as needed).

What prior actions have been executed and have become successfully institutionalized changes?

What prior actions are still in progress?

Are any prior actions tabled because they cannot be accomplished at the present time? Why?

Action Log

It is important to document each action the CAT accomplishes, and to file it along with any program materials developed as a permanent record of program accomplishments.

Briefly describe the following:
1. Issue (why the action was implemented)

_________________________________________________________________________________________
_________________________________________________________________________________________

2. Recommended Action (include category of action, if use classification scheme)

_________________________________________________________________________________________
_________________________________________________________________________________________

3. Action steps (list each activity as it is implemented to accomplish the action; indicate the involved agencies/organizations and date when completed. Attach any materials developed for this action, such as pamphlets, policies, screening tools, training agendas, etc.)

_________________________________________________________________________________________
_________________________________________________________________________________________

4. Lasting effects in Community (identify what changes have been observed as a result of community action)
Form FA7-2: Quarterly CAP Status Report

Staff Name: __________________________________________________   Staff ID:___________     Date (dd/mm/yy): _____________________

Community Name:________________________________________________   Community Number:_______________

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<th>Community Leader Last Name</th>
<th>Community Leader First Name</th>
<th>CAP ID</th>
<th>Date CAP initially drafted</th>
<th>Date CAP submitted to EGPAF</th>
<th>Date CAP revised</th>
<th>CAP activities initiated this reporting period</th>
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Form FA7-3: CAP Update Report

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<td>Date (mm/yyyy):</td>
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<td></td>
<td>Date CAP revised</td>
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</tbody>
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Describe revisions and reasons for revision:

Accomplishments

Challenges

Lessons Learned

List of Resources


*SASA!* Mobilizing Communities to Inspire Social Change

Health Communication Partnership. How to become a champion community.

Uganda Family Support Group Manual


World Health Organization. Gender and Rights in Reproductive Health

International HIV AIDS Alliance. Tools together now! 100 participatory tools to mobilise communities for HIV/AIDS. 2007

International HIV AIDS Alliance. 100 Ways to Energise Groups: Games to Use in Workshops, Meetings and the Community. 2003


<table>
<thead>
<tr>
<th>Activity Name</th>
<th>Facilitator</th>
<th>Duration</th>
<th>Materials &amp; Resources</th>
<th>Methodology</th>
<th>Discussion Issues/Questions to expect</th>
<th>Expected Outcomes</th>
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### EGPAF Evaluation of Community Leaders’ Institute

| District/Region Name: | Date: ___ ___ - ___ ___ - ___ ___  
<table>
<thead>
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<tbody>
<tr>
<td></td>
<td>Day – Month – Year</td>
</tr>
<tr>
<td>Cluster Name &amp; Country:</td>
<td>Venue:</td>
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</tbody>
</table>

#### Facilities

31. How would you rate the overall quality of the space?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Code</th>
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<tbody>
<tr>
<td>Very good</td>
<td>(1)</td>
</tr>
<tr>
<td>Good</td>
<td>(2)</td>
</tr>
<tr>
<td>Poor</td>
<td>(3)</td>
</tr>
<tr>
<td>Very poor</td>
<td>(4)</td>
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</tbody>
</table>

32. Was there enough physical space for participants to be comfortable?

<table>
<thead>
<tr>
<th>Response</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>(1)</td>
</tr>
<tr>
<td>No</td>
<td>(2)</td>
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</tbody>
</table>

33. How would you rate the comfort facilities at this venue?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very comfortable</td>
<td>(1)</td>
</tr>
<tr>
<td>Comfortable</td>
<td>(2)</td>
</tr>
<tr>
<td>Uncomfortable</td>
<td>(3)</td>
</tr>
<tr>
<td>Very uncomfortable</td>
<td>(4)</td>
</tr>
</tbody>
</table>

34. How would you rate the dining facilities at this venue?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>(1)</td>
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<tr>
<td>Good</td>
<td>(2)</td>
</tr>
<tr>
<td>Poor</td>
<td>(3)</td>
</tr>
<tr>
<td>Very poor</td>
<td>(4)</td>
</tr>
</tbody>
</table>

35. How would you rate the audio-visual facilities at this venue?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>Very good</td>
<td>(1)</td>
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<tr>
<td>Good</td>
<td>(2)</td>
</tr>
<tr>
<td>Poor</td>
<td>(3)</td>
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</tbody>
</table>
Very poor (4)

**Organization**
36. How would you rate the project team’s organization?

- Very organized □ (1)
- Organized □ (2)
- Disorganized □ (3)
- Very disorganized □ (4)

37. How would you rate the project team’s communication?

- Very good □ (1)
- Good □ (2)
- Poor □ (3)
- Very poor □ (4)

38. Were expectations, norms and rules clarified prior to starting the workshop?

- Yes □ (1)
- No □ (2)

39. Were participants given an opportunity to introduce themselves and to know the facilitation team?

- Yes □ (1)
- No □ (2)

**Materials and supplies**
40. How would you rate the quality of hand-outs and participant manuals?

- Very good □ (1)
- Good □ (2)
- Poor □ (3)
- Very poor □ (4)

41. How would you rate the adequacy of supplies for participants?

- Very good □ (1)
- Good □ (2)
- Poor □ (3)
- Very poor □ (4)

**Appropriateness of the content of the workshop**
42. How would you rate the appropriateness of the topics covered in this workshop (just right, insufficient, too much material)

- Very appropriate □ (1)
- Appropriate □ (2)
43. How would you rate the appropriateness of the exercises, ice breakers and small group sessions? (Just right, etc.)

- Inappropriate  
- Very inappropriate

44. How would you rate overall time management for this workshop?

- Very good
- Good
- Poor
- Very poor

45. Was the time allotted to cover each session sufficient?

- Yes
- No

46. Did the workshop start punctually as scheduled?

- Yes
- No

47. Was there sufficient time for the breaks throughout the day?

- Yes
- No

48. Was there enough time for participant interactions, sharing and small group sessions?

- Yes
- No

49. Was there enough time for questions to be asked and answered?

- Yes
- No

50. How would you rate the facilitation team for this workshop?

- Very good
- Good
- Poor
- Very poor
51. Were there enough facilitators for the workshop?
   Yes ☐ (1)
   No ☐ (2)

52. Were the facilitators skilled and knowledgeable?
   Yes ☐ (1)
   No ☐ (2)

53. Did the facilitators routinely check to ensure that the workshop meets your expectations?
   Yes ☐ (1)
   No ☐ (2)

**Follow up plans**
54. Did you have sufficient time to discuss follow up plans?
   Yes ☐ (1)
   No ☐ (2)

55. Were the follow up plans for you as an individual clear?
   Yes ☐ (1)
   No ☐ (2)

56. Were the follow up actions for the facilitation/project team clear?
   Yes ☐ (1)
   No ☐ (2)

**Suggestions**
57. One thing to change about the workshop
   _______________________________________________________
   _______________________________________________________

58. One thing to remove from the workshop
   _______________________________________________________
   _______________________________________________________

59. What is one thing you liked about this workshop?
   _______________________________________________________
   _______________________________________________________

60. Do you have any other thoughts?
   _______________________________________________________
   _______________________________________________________
Form RA4: Community Leaders’ Institute Workshop Report Template

Cover page (Community/Cluster name, venue, dates)
Table of contents
Workshop Objectives
Workshop Agenda
Workshop Facilitators
Opening Remarks
Deliberations
  Summary of discussions
  Questions and answer summary
Breakthrough opportunities
Challenges
  Technical topics that need revisiting
  Logistical challenges
Next Steps (Participant commitments to the project)
Follow up items (EGPAF staff commitments to participants, with timelines)
  Priorities for refresher trainings
  Mentorship needs
Appendices:
  List of participants
  Summary of workshop evaluations
  Summary of mentorship plans
  Images
Community Day Tools

Contents

Community Dialogue Guide

These provide guidance to dialogue facilitators on how to conduct the discussions and bring out the important issues faced by community members around MCH and PMTCT. Each dialogue guide is tailor-made according to the target group but all the discussions are centered around MCH and PMTCT.

Community Day SOP

This SOP outlines how Community Days should be conducted by staff and in partnership with the communities where these will be implemented. It addresses the recruitment process of dialogue facilitators and their training. It also illustrates the situational analysis that should be done in communities before conducting the community days so that the issues discussed during the community day address the precise health challenges of the communities.

Community Day Forms
These forms enable tracking of the proceedings of the day through registration of participants in services provided during. In these forms a tracker for day referrals and a template for exit interviews can be found. These forms serve as an important tool for staff to track and document the process and the outputs of the community day intervention.

Community Day Dialogue Guides

Male Youth Dialogue Guide: How we learn about sex, healthy relationships and avoiding HIV

1. What kind of health education is the males’ youth exposed to?
   *Facilitators Probes*
   - How do youth males learn about sex? What are the most reliable sources of information for learning about sex? (in school; from family and friends)
   - What actions can male youth take to stay healthy? Who can they go to for support in both their personal health and in the health of their relationships?
   - What are qualities of a healthy relationship between men and women?
   - How does a boy know when he is mature enough to have sex?
   - How should a boy’s family teach him how to have healthy relationships with women?

2. What do male youth know about HIV?
   *Facilitators Probes*
   - How is HIV acquired? What are the behaviors within our community that propel the spread of HIV?
   - If you are sexually active, why is HIV testing important?
   - Where can you go to get an HIV test in the community?
   - What can we do to encourage youth males to go for HIV testing?

3. How can we prevent the spread of HIV and other STIs?
   *Facilitators Probes*
   - In this community, what influences a young boy to delay sex?
   - How can we discourage men (and women?) from having multi concurrent partners?
   - How can we encourage faithfulness to one partner at a time?
   - What are barriers to using condoms? How can we encourage youth males to correctly and consistently use a condom during sex?
   - What are the myths associated with condom usage in both male and female condoms?
What is surgical male circumcision, and how can this help with the prevention of HIV transmission?
Are condoms for both males and females accessible in our community? Where?
Do we think medical male circumcision prevents the spread of HIV?

ANC Attendance
1. Why is it important for women to attend ANC during pregnancy?

Facilitators Probes
- Why should pregnant woman attend ANC?
- What can we do as a community to encourage pregnant woman to attend ANC as recommended?
- What else can a woman do to remain healthy during her pregnancy?
- How can men help women remain healthy during pregnancy?

Labor and Delivery
1. Why is it important for women to deliver their babies at a health facility?

Facilitators Probes
- What are some barriers that prevent women from going to a health facility for their delivery? What are the dangers of at-home deliveries?
- Who can support a woman to have a facility-based birth? What are the key elements for birth and emergency preparedness? How can men support women to plan for their child birth?
- What kind of support do you expect from your family, friends and community if you happen to impregnate a girl?

Postnatal Care/ Child Welfare Uptake, Demand, Retention, and Joint Decision Making
1. What are the benefits of receiving post-natal care (PNC) for a mother and her baby?

Facilitators Probes
- Are there barriers for mothers not to come with their children for their six week visit?
- How can these barriers be addressed?
- What support can be given to the mother and her baby during the PNC period (partner, family, and community)?
2. What type of advice do women receive in caring for their newborns? What are examples of cultural practices in caring for newborns?

Facilitators Probes
- Is all advice received healthy advice?
- Who should support women with the care of the newborn baby?
- How can women be supported to follow advice received from the health care workers at the health facility?
1. What kind of health education is the female youth exposed to?

**Facilitators Probes**
- How do girls learn about sex? What are the most reliable sources of information for learning about sex? (in school; from family members and friends)
- What actions can female youth take to stay healthy? Who supports female youth in their personal health and in the health of their relationships with men?
- Is it important for a young woman to go to the health facility if she is considering having sex with her partner? Why?

2. How can female youth plan for motherhood?

**Facilitators Probes**
- How does a girl know when she is mature enough to have sex?
- In this community, what would influence a girl to delay sex?
- Why do girls in our community fall pregnant early?
- What actions can a young woman take to avoid unwanted pregnancy?
- Why do some girls want to wait to have a baby, while others want one sooner?

3. How much do girls know about HIV?

**Facilitators Probes**
- How is HIV acquired?
- How can we prevent the spread of HIV and other STIs within our community? What is safe sex?
- Are condoms readily accessible in the community? Where/How?
- Would you feel comfortable accessing condoms? And asking your partner to use a condom? Why/why not?

*Keeping yourself healthy during pregnancy*

1. How do girls learn about pregnancy and motherhood? (in school; from family members and friends)

**Facilitators Probes**
- What kind of support do you expect to receive from your family, friends and community during the pregnancy and motherhood period?

2. Why is it important to go to the clinic when you think you are pregnant?

**Facilitators Probes**
- How soon should someone start ANC?
- What are the barriers that keep girls from attending ANC early?
- How can these barriers be addressed?
• Why is it important to book early, come back for all of your visits, and follow the advice of the nurse?

3. **How can an HIV positive woman protect her unborn baby from being infected with HIV during pregnancy?** (emphasize condom usage)

*Facilitators Probes*
- What support does a woman need to prevent passing HIV to her infant during pregnancy?
- What is the importance of adhering to prescribed medication for HIV+ mother and HIV exposed baby?

**Labor and Delivery Uptake, Demand and Joint Decision-Making**

1. **How can women prepare for childbirth?**

*Facilitators Probes*
- Who should be involved in supporting women for the preparation of childbirth?
- How soon should a couple start preparing for childbirth?
- What are the key elements for birth and emergency preparedness?
- What are the barriers for birth and emergency preparedness?

2. **Why is it important for a pregnant youth to deliver in a health facility?**

*Facilitators Probes*
- In this community, what prevents girls from delivering in a health facility?
- What are the dangers of at-home deliveries?
- What support do pregnant girls need to deliver in a health facility?

3. **Why is it important for all pregnant women to get tested or re-tested for HIV during labor and delivery?**

*Facilitators Probes*
- Why is it important to retest during labor and delivery?

**Postnatal Care/ Child Welfare Uptake, Demand, Retention, and Joint Decision-Making**

1. **What are the benefits of receiving PNC/CWC for a mother and her baby?**

*Facilitators Probes*
- When are the routine PNC/CWC visits?
- Are there any barriers that prevent mothers from coming with their children for their six week visit?
- How can these barriers be addressed?
- What support can be given to a mother and her baby during the PNC period (partner, family, and community)?
2. What type of advice do women receive in caring for their newborns? What are examples of cultural practices in caring for newborns?

Facilitators Probes
- Is all advice received healthy advice?
- Who supports women with their care of the newborn baby?
- Who influences or promotes cultural practices?
- How can women be encouraged to follow advice received from the health care workers at the health facility?
Male Adults Dialogue Guide:

1. **Why is it important for women to remain healthy during pregnancy?**

   *Facilitators Probes*

   - What are the benefits of pregnant women attending ANC (at least four times during a pregnancy)? Have you ever attended ANC with your partner?
   - How would you react if your pregnant partner asked you to attend ANC with her?
   - What are some barriers women face to attending ANC during their pregnancy? How can men support women to attend ANC?
   - What are the danger signs in a pregnancy? What support should a woman receive if any danger signs are present?
   - What services are available for men at the health facilities? Why is this important?

2. **How is HIV transmitted?**

   *Facilitator’s Probes*

   - How can HIV be prevented? In cases of sero-discordance among partners, how can transmission from the HIV positive partner to the HIV negative partner be prevented?
   - How can HIV negative women remain negative during pregnancy and throughout breastfeeding?
   - Why is condom use important during pregnancy and breastfeeding? (Include condom demonstration)
   - How can an HIV positive woman protect her unborn baby from getting HIV during pregnancy?
   - Why is it important for both partners to do an HIV test when a woman is pregnant?
   - How would you feel if your partner asked you to go with her to the facility to do HIV testing?
   - Why is it important for both partners to retest during labor and delivery? And during the breastfeeding period?
   - How can women be supported to follow all advice received during ANC and take their medicines as prescribed by a health care worker?
   - Why is it important for males to circumcise as a method of HIV prevention?
   - What are the common STIs that are prevalent in our communities? What is the effect of these on unborn children? How can this be prevented?

### Labor and Delivery Uptake, Demand and Joint Decision-Making

1. **Why is it important for women to deliver her baby in a health facility?**

   *Facilitator’s Probes*
• What are the dangers of an at-home delivery?
• In this community, what are the barriers that prevent women from delivering in a health facility, and what role can men play in helping to overcome these barriers?
• What can the community do to help ensure women deliver in health facilities?
• What are the key elements of birth and emergency preparedness?

Postnatal Care/Child Welfare Uptake, Demand, Retention and Joint Decision-Making

1. Why is it important for a women and her baby to receive PNC/CWC services?

Facilitator’s Probes

• Are there barriers that prevent mothers from coming with their children for their six week visit?
• How can these barriers be addressed?
• What support can be given to the mother and her baby during the PNC period (partner, family, and community)?

2. What type of advice do women receive in caring for their newborns? What are examples of cultural practices in caring for newborns?

Facilitators Probes

• Is all advice received healthy advice?
• What are the benefits of breastfeeding?
• Who should support women with the care of the newborn baby?
• How can women be supported to follow advice received from the health care workers at the health facility?
• Why is it important for the baby to receive an HIV test if either you or your partner is HIV positive?

3. What are the benefits of joint decision-making between in a relationship?

Facilitator’s Probes

• Who in the family should decide when to have another child?
• How can another pregnancy be delayed or avoided?
• If you and your partner agree to delay the arrival of another baby in the family, who should decide what type of family planning method or contraception to use?
• What role can men play in ensuring the health of the family?
1. **Why is it important for pregnant women to go to the health facility for ANC?**

   **Facilitator’s Probes**
   
   - What are the advantages of booking early for ANC? What are the benefits of attending ANC frequently – at least four times during pregnancy?
   - What are the barriers that women face in attending ANC early and during their pregnancy?
   - Why is it important for men to accompany their partners to ANC?
   - What can our community do to ensure women and their partners attend ANC as recommended?
   - What are the danger signs in a pregnancy? What support should a pregnant woman receive if any danger signs are present?
   - Why is HIV testing for both the woman and her partner important during ANC and throughout the breastfeeding period?
   - How can women be supported to follow all advice received from the health care workers during ANC and to adhere to all medicines received during ANC?
   - What are some of the experiences that women in this community have when attending ANC? What are the recommendations for improvement?

2. **How is HIV transmitted?**

   **Facilitator’s Probes**
   
   - How can HIV be prevented?
   - What precautions can an HIV negative woman take to remain negative, even if her partner is HIV positive?
   - Why is condom use important during pregnancy and breastfeeding? (Include condom demonstration)
   - How can an HIV positive woman protect her unborn baby from getting HIV?
   - Why is it important for both partners to do an HIV test when a woman is pregnant?
   - Why is it important for both partners to retest during labor and delivery? And during the breastfeeding period?
   - Is it easy to follow all advice received during ANC and take medicines as prescribed by a health care worker? Who can support you?

---

**Labor and Delivery Uptake, Demand and Joint Decision-Making**

1. **Why is it important for a pregnant woman to deliver in a health facility?**

   **Facilitator’s Probes**
   
   - What are the dangers of an at-home delivery?
• In this community, what are the barriers that prevent women from delivering in a health facility, and what role can you and your family play in helping to overcome these barriers?
• What can your family do to help ensure women deliver in health facilities?
• What are the key elements of birth and emergency preparedness?

2. What are the signs of labor

Facilitator’s Probes

• What are the danger signs during labor and delivery?
• What traditional medications (i.e.: masheshisa) are commonly used during labor? What are the dangers of using medicines that are not prescribed by a health care worker?
• How can women be supported to follow the advice of health care workers and adhere to medicines prescribed by the health care worker?

Postnatal Care/ Child Welfare Uptake, Demand, Retention and Joint Decision-Making

1. Why is it important for a women and her baby to receive PNC/CWC services?

Facilitator’s Probes

• Are there any barriers that prevent mothers from coming with their children for their six week visit?
• How can these barriers be addressed?
• What support can be given to the mother and her baby during the PNC period (partner, family, and community)?
• What is the infant feeding recommendation for all mothers?
• What are the barriers mothers in this community face in adhering to this recommendation?
• What are the benefits of breastfeeding? How can mothers be supported to exclusively breastfeed for six months?
• If a baby tests positive for HIV, what are the necessary precautions to keep him/her alive and healthy? (Include adherence to medications for mother/baby).
• If a baby tests negative for HIV, what are the necessary precautions to keep him/her alive and healthy? (Include retesting and dual protection).
• What are the cultural practices that can affect maternal and child health?
• How can we address these harmful practices as a community?
Women at Child Bearing Age:

1. Why is it important for women to remain healthy during their pregnancy?

   **Facilitators Probes**
   - What are the benefits for pregnant women to attend ANC?
   - What are the advantages of booking early for ANC? What are the benefits of attending ANC frequently?
   - What are some barriers that women face in attending ANC during their pregnancy? How can these challenges be overcome?
   - Have you ever brought your partner with you to an ANC visit? If not, would you feel comfortable doing so?
   - What are the danger signs in a pregnancy? How can you get help if you experience these danger signs?

2. How is HIV transmitted?

   **Facilitator’s Probes**
   - How can HIV be prevented?
   - What precautions can an HIV negative woman take to remain negative, even if her partner is HIV positive?
   - Why is condom use important during pregnancy and breastfeeding? (Include condom demonstration)
   - How can an HIV positive woman protect her unborn baby from getting HIV?
   - Why is it important for both partners to do an HIV test when a woman is pregnant?
   - Why is it important for both partners to retest during labor and delivery? And during the breastfeeding period?
   - Is it easy to follow all advice received during ANC and take medicines as prescribed by a health care worker? Who can support you?

Labor and Delivery Uptake, Demand and Joint Decision-Making

1. Why is it important for a woman to deliver her baby in a health facility?

   **Facilitator’s Probes**
   - What are the dangers of an at-home delivery? What are the advantages of delivering in a health facility?
   - In this community, what are the barriers that prevent women from delivering in a health facility? How can these barriers be overcome?
   - What are the key elements of birth and emergency preparedness?

2. What are the signs of labor?

   **Facilitator’s Probes**
   - How soon should a pregnant woman arrive at a health facility after her labor begins?
   - What are the danger signs during labor and delivery?
• What are the dangers of using traditional medicines during labor and delivery? What are the dangers of using any medicines not prescribed by a health care worker during labor and delivery?
• Why is it important for a woman to get an HIV test during labor and delivery, even if she received an HIV test during ANC?
• Why is it important to adhere to all medicines prescribed by the health care worker?

Postnatal Care/Child Welfare Uptake, Demand, Retention and Joint Decision-Making

1. Why is it important for a woman and her baby to receive PNC/CWC services?

Facilitator’s Probes
• What are the routine PNC/CWC visits?
• What services are offered at the seven day visit for the mother and the baby?
• What services are offered at the six week visit for the mother and the baby?
• Are there barriers that prevent mothers from coming to the facility for routine postnatal follow-up? How can these barriers be overcome?
• What are the benefits of breastfeeding? Why is it important to exclusively breastfeed for the first six months of the baby's life? What barriers do women face to exclusively breastfeeding?
• Why is repeat HIV testing important?
• If a mother tests HIV positive, what needs to be done to protect the baby from acquiring HIV and to keeping the mother healthy?
• Why is it important for a mother and her baby to remain in care and follow the advice of the health care worker?

2. What types of advice do women receive in caring for their newborns? What are examples of cultural practices in caring for newborns?

Facilitators Probes
• Is all advice received healthy advice?
• What are the dangers of taking medicines that are not prescribed by the health care worker?
• What are traditional practices that prevent a woman from exclusively breastfeeding? How can these barriers be overcome?

3. What are the benefits of joint decision-making between in a relationship?

Facilitator’s Probes
• Who in the family should decide when to have another child?
• How can another pregnancy be delayed or avoided?
Community Day SOP

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Introduction

1. **Target audience for these Tools**

   The Standard Operating Procedures (SOPs) provide critical and specific guidance on supporting EGPAF implementation staff and other staff from various stakeholders that will be engaged in implementing Community Days. Specifically the SOPs targets:

   a. Country Project Coordinators
   b. Community Day Planning Committee
   c. Strategic Information and Evaluation Officers
   d. Research Officers
   e. Data Collectors

2. **Purpose/objectives of the SOPs**

   These SOPs provide standardized guidance for conducting Community Days for the EGPAF project. The objectives are to:

   k. Provide a comprehensive outline of roles and responsibilities necessary in implementing the intervention
   l. Provide guidance on planning for the Community Day
   m. Provide guidance on conducting the Community Day
   n. Provide guidance on documentation for Community Day

3. **How the SOPs should be used**

   These SOPs address recruitment, training, supportive supervision, assessment and data collection for the implementation of the Community Days intervention. They should be used along with other research and implementation resources to ensure that each country team executes the intervention according to the set quality standards. Each country team should adapt the SOPs in line with national policies, team member roles and existing country program implementation strategies.

4. **Purpose of the Community Day**

   The Community Day provides an opportunity to create dialogue within a community about health issues that relate to maternal and child health. It will bring various ages and genders together and bring awareness about issues around MNCH and male involvement, as well as issues that prevent women from accessing critical services. It also provides an opportunity to bring some services closer to the communities for men, women, pregnant women and children. The minimum service package is always HIV testing and referral – in addition, there are diagnostic (and not curative services) such as blood sugar testing, growth monitoring and screening for high blood pressure and TB. It can be a platform to identify and link women who are pregnant and have not received services and those who have abnormal tests and clinical indications to the appropriate clinical care.

5. **Community Day Service Package**

   A minimum package of services is to be provided at each Community Day, along with additional services as determined by the country and community context. The minimum package shall include:
   - HIV counselling and testing
   - HIV prevention information and counselling
• Pregnancy counselling and testing (if available)
• Blood pressure screening
• Glucose screening
• Growth monitoring for children (MUAC)
• Family planning information
• TB screening
• Referrals to appropriate health services

Additional services may be added as available or necessary for the country or community context. All services provided must be clearly documented in the Community Day report.

6. New Terminology

Community Day
An event in which people from the same community gather in a central point to receive critical health information and services, focusing on Maternal New-born Child Health (PMTCT/MNCH) barriers. This event includes facilitators who assist the community in exploring local solutions to combat the barriers to accessing and demanding quality health services.

Implementing Staff:
The implementing staff includes personnel from EGPAF, community leaders, focal people from MOH and representatives from stakeholders.

Community Day Facilitators:
Individuals who attend orientation and are equipped to lead structured discussions within small dialogue groups during the Community Days. A facilitator should be a person with good communication skills, public speaking abilities and familiarity with health issues (especially MNCH in the community). Staff or volunteers from the DHMT, MOH, NGO, CBO, etc., can be equipped for this role. Male facilitators should lead the all-male groups; female facilitators the all-female groups.

Community:
A community is body of persons or nations having a common history or common social, economic and political interests. For the purposes of EGPAF, a community is also a geographic grouping of individuals.

Training of Trainers (TOTs)
EGPAF staff and/or consultants who have completed the entire course of the TOT training, demonstrated mastery of the knowledge and approaches, and participated in the planning and implementation of the full four-day Community Leaders’ Institute.

ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>CANGO</td>
<td>Coordinating Assembly of Non-Governmental Organizations</td>
</tr>
<tr>
<td>CAP</td>
<td>Community Action Plan</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<tr>
<td>CPC</td>
<td>Country Project Coordinator</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>EC</td>
<td>Expert Client</td>
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</tbody>
</table>
7. **Principles of a Successful Community Day**

1. **Appropriate entry:**
   
The implementing staff should ensure all protocols are observed for community entry. Involvement should start from the national Ministry of Health (MOH); Regional/District Health Management Teams (R/DHMTs); constituency and community leaders; health facility staff; Community Based Organizations (CBOs) and Faith Based Organizations (FBOs).

2. **Identification of the appropriate stakeholders:**
   
The implementing staff for the area should ensure that all stakeholders, both those involved with EGPAF and others who may not be, have been identified to ensure broad community representation, buy-in, resource sharing and avoidance of duplication.

3. **Effective stakeholder involvement:**
   
The implementing staff should ensure that all stakeholders are consulted and informed well in advanced and are actively involved in the planning and implementation of the event. These should include: MOH, R/DHMTs, community leaders, facility staff, CBOs and FBOs.

4. **Community Leadership:**
   
The implementing staff, with assistance from the local clinic staff and clinic committee, should mobilize social and cultural leadership within communities. Their focus should be on integrating community ideas and initiatives for the transformation of values, social norms, and individual behaviors.

5. **Visibility:**
   
Communication should utilize all appropriate vehicles available, with local media and local interpersonal personal communication serving as mutually reinforcing
vehicles. Exposure to the issues and messages from the Community Day should go beyond just provision of information to include activities for building the skills needed to enact the change of values, social norms, and individual behaviors.

6. **Local coordination:**
The implementing staff should manage implementation across the spectrum of HIV and health agencies to fill service gaps, facilitate consistency in messages and maximize synergies. Community Days provide an opportunity to build partnerships within and across sectors and to create even greater efficiencies in access to health information and health services.

![Figure 3. Community Day SOP Flow Chart](image-url)
SOP B-0: Roles and Responsibilities

I. Purpose

The purpose of this SOP is to provide overall guidance on the roles and responsibilities for those involved in planning and conducting a Community Day.

II. Roles and Responsibilities

1. Project Coordinator:
   a. Ensure that adequate facilitators are recruited and trained.
   b. Ensure that EGPAF program officers follow the standard operating procedures (SOPs) for the intervention.
   c. Ensure that a MOH focal person is identified for each Community Day.
   d. Ensure that all the teams and stakeholders (planning committee, partners, facilitators, etc.) are appropriately informed, engaged, and assigned the various roles and responsibilities.
   e. Ensure that all services to be provided are availed and well-coordinated.
   f. Ensure the development of an agenda for each event, based on local input.
   g. Take responsibility for the effective flow of communication and information throughout the planning, implementation and follow up.
   h. In liaison with the M & E officer, ensure that the data collection tools are available and information is entered correctly.

2. EGPAF Staff:
   a. Ensure that the purpose of the planning committee is well understood.
   b. Ensure that the meeting of the planning committee is well coordinated and supervised.
   c. Ensure that plans of the committee are documented and shared with EGPAF management.
   d. Ensure that resources to support these meetings are availed and well organized.
   e. Ensure that the logistics and content of the Community Day are well-planned and executed and that proper reporting and follow-up are conducted.

3. Facilitators:
   a. Organize members for the various group discussions at the Community Day.
   b. Direct participants to the different services after the group discussions.
   c. Assist with capturing of data using the different forms.
   d. Assist with facilitation of group discussion.
   e. Take notes from the group discussions.
   f. Conduct exit interviews.
   g. Disseminate men’s and women’s group information.
   h. Recruit members for the MCH classes and the men’s peer groups (only in Arm 3, where peer group intervention will be implemented).
SOP B-1: Preparing for the Community Entry Process

I. Purpose

The purpose of this SOP is to provide overall guidance on the roles and responsibilities of the Project Coordinator when planning and conducting a Community Day.

II. Roles and Responsibilities

The EGPAF Project Coordinator will ensure that:

1. The appropriate communication channels (from the national to the district/sub-district level) are identified and engaged throughout all stages of planning, implementation and follow up.
2. EGPAF Community Leaders are actively engaged.
3. EGPAF leadership is appropriately briefed and engaged throughout the intervention planning and implementation, particularly at the national level.
4. EGPAF regional/district staff are appropriately briefed and engaged throughout the intervention planning and implementation, particularly at the regional/district levels.

III. Procedures

1. Identify all the appropriate national-level departments, units and ministries whose buy-in and approval are required for the Community Days to be planned, funded and implemented.
2. Engage EGPAF leadership in securing buy-in from the appropriate offices for the Community Days intervention – this buy-in should preferably be secured in writing to facilitate subsequent sub-national correspondence and meetings.
3. Having secured buy in from the appropriate departments and units at the national level to conduct the Community Day intervention, initiate the appropriate Regional/District level entry protocols.
4. Request and conduct meetings with the relevant key regional/district offices, (such as the Regional Executive, Regional Health Administrator, Regional Matron, Regional structure of the traditional authorities, etc.) to introduce the Community Day intervention, secure buy-in, and ensure commitment of human and financial resources.
5. Schedule and hold planning meetings with the regional health management teams (RHMT/WHC) members, in order to secure guidance on the structures to mobilize during community entry.
6. Secure the name(s) of the R/DHMT’s focal person to link the MOH, EGPAF implementation team, community and partners at the regional level.
SOP B-2: Conducting a Health Situational Analysis of the Area

I. Purpose

The purpose of this SOP is to give guidance in conducting a health situation analysis for the Community Day so that all stakeholders involved could be identified. Also, the information obtained here gives the planners a picture about prevailing key challenges of the area.

II. Roles and Responsibilities

EGPAF Staff is responsible for:
1. Supporting the process of examining MNCH/PMTCT general trends, gaps and social/behavioral obstacles to change.
2. Supporting the identification of health services and available potential resources.
3. Involving trained Community Leaders in understanding the health context of their area so as to inform the development of the Community Action Plan.
4. Involving the stakeholders in describing the current context of the community.
5. Sharing collected information with all the relevant stakeholders.

III. Procedure

A health situation analysis is an activity that collects all relevant health and health services information about the area so that interventions directed to the area are relevant. This exercise involves exploring type of stakeholders available in the community (NGOs, FBO, CBO, and others), major health issues, myths, misconceptions, threats, power structure, communication channels, resources and assets of the community.

1. Examine the general trends and patterns for the major MNCH/PMTCT outcomes (e.g. Completion of PMTCT cascade by HIV+ women; uptake of ARVs prophylaxis/ART for HIV exposed infants; early uptake of Early Infant Diagnosis HIV testing and retesting of women before and during delivery; ANC attendance before 20 weeks; facility delivery; attendance of postnatal care (4-6 weeks). This information will be obtained from the health care workers from the facilities in these communities.
2. Explore the main gaps contributing to these trends and identify the desired changes (e.g. Do women attend ANC early enough? What are the rates of institutional deliveries?).
3. Discuss and examine the social and behavioral obstacles that need to be changed (e.g. What are the specific health beliefs and health-seeking behaviors in this community? What are the prevalent myths and misconceptions – if any? Do specific gender and power structures limit access and utilization of MNCH/PMTCT services for certain populations?).
4. Describe current community context (e.g. Are most people unaware of the MNCH/PMTCT status of their communities? Are communities in denial? Are community leaders and major institutions willing and ready to consider the need for change and find solutions to the major challenges? Are people resistant to change and unwilling to work together?)
5. Examine potential resources (e.g. What are the major communication channels? What kinds of community structures could be mobilized? What are the media outlets?)
6. Data about the above can be obtained from the local health facilities, local constituency (Inkhundla), community based organizations, demographic health surveys, etc.
7. The analysis should be discussed with the community leaders in depth so that they can use this information to develop their local Community Action Plans.
8. The collected information can be shared at a later time with all the relevant stakeholders so that they have a better understanding about the situation in the area concerning MNCH services.

IV. Resources
1. Form FA-xx CAP templates
SOP B-3: Conducting the Stakeholder Consultations

I. Purpose

The purpose of this SOP is to provide guidance on the stakeholder consultation for providing information, obtaining buy-in and planning for a Community Day.

II. Roles and Responsibilities

The EGPAF Staff will be responsible for:

1. Identifying the different stakeholders that will be important for organizing the Community Day.
2. Consulting the stakeholders and informing them about the Community Day aims, objectives, activities, requirements and intended outcomes plans to hold the Community Day.
3. Involving trained community leaders in meetings with stakeholders as appropriated.
4. Solicit membership of the planning committee for the Community Day.

III. Procedures

1. Together with the R/DHMT focal person:
   a. Determine and identify the appropriate health facilities to host and support the Community Day event, based on considerations such as: facility level/grade, site-level service utilization statistics, site capacity, size of the catchment area, presence/absence of implementing partners, etc.
2. With the Health Facility:
   a. Ask the health facility leadership to identify the focal person(s) who serve as the facility’s liaison for all planning, communications, implementation, and documentation.
   b. Through the focal person, request for meetings with health facility staff and community health committee members.
   c. During the meetings with the health facility staff, introduce the idea of Community Days, secure their buy, and discuss how to engage the community in order to ensure the success of the intervention.
   d. Ensure that the health facility staff and health committee members are informed and thoroughly apprised of their leadership role in planning, conducting and following up the Community Day.
   e. Working with the facility staff and health committee members, develop a plan to involve other stakeholders, e.g. FBO, CBO, as well as community leadership.
   f. Thoroughly debrief the focal person(s) about their roles and responsibilities and the potential time commitments.
   g. Confirm the focal persons preferred communication modes for liaising with the EGPAF project team.
3. With the community stakeholders:
   a. Through the relevant/spokesperson for the community leadership, request for a
      meeting with the community leadership.
   b. Call/visit the relevant community leadership structures (e.g. chiefs, traditional
      and political leaders, etc.) to briefly introduce the Community Day intervention
      and identify any additional stakeholders who were not identified during the
      situation analysis.
   c. Secure contacts for each of the recommended stakeholders.
   d. Request a meeting with all identified stakeholders.
   e. During the meetings with the community stakeholders, introduce the aims,
      objectives, activities, and intended outcomes of the Community Days and secure
      their commitment with leveraging resources and conducting social mobilization
      within all segments of the community.
   f. Ask the community leadership structures and each key stakeholder to appoint a
      focal person to link the MOH, EGPAF implementation team, community health
      facility and partners at the community level.

IV. Resources
1. List of stakeholders
2. Facility focal person list
3. Planning committee names and contacts
SOP B4: Recruiting the Community Day Planning Committee

I. Purpose

The purpose of the pre-day meetings is to bring the planning team together and develop a shared vision, discuss issues that need to be addressed at the Community Day, identify the target population, and work on logistics for the Community Day. A planning team should be selected which should hold several (a minimum of two) meetings prior to the Community Day event.

II. Roles and Responsibilities

EGPAF staff should:

1. Ensure that all stakeholders invited have representatives on the planning committee.
2. Support selection of the Community Day planning committee, which should involve all stakeholders.
3. Ensure that roles and responsibilities or terms of reference for each committee are assigned.
4. Schedule dates and venue of the meetings. This should be agreed by all, to ensure good attendance.
5. Develop a work plan and set targets for the committee.

III. Procedure

1. Contact the designated focal points from the key stakeholder groups and discuss the importance of selecting the Community Day planning committee.
2. Confirm with each designated focal point, whether they have the time and availability to participate in the community planning committee.
3. In cases where the designated focal point is unable to participate fully in the activities of the community planning committee, request that they identify and name a second representative who is better suited to participate.
4. Compile the names, designations and contact information for all planning committee members and secure their permission to disseminate this information.
5. Share the draft terms of reference, roles and responsibilities with the planning committee members.
6. Schedule the first meeting of the planning committee to assign roles and responsibilities, refine the TOR, and develop the work plan and timeline.

IV. Resources

1. Form FB1- Committee Member Roster
SOP B-5: Community Day Planning Committee Terms of Reference

I. **Purpose**

This SOP outlines the terms of reference of the planning committee.

II. **Roles and Responsibilities**

1. **EGPAF Staff will ensure that:**
   a. The terms of reference covers all responsibilities of the committee.
   b. The terms of reference are shared, reviewed, agreed upon, and adopted by all the committee members.
   c. Committee is thoroughly oriented on their roles and responsibilities.
   d. A committee chairperson is chosen and agrees to take on the leadership role of the committee.
   e. There is a common understanding on when to meet, what to do and how often meetings between the committee and EGPAF staff should occur.

2. **A Planning Committee Chairperson is chosen in each community and will fulfill the following:**
   i. Schedule regular and special-purpose meetings
   ii. Develop and circulate agenda package
   iii. Facilitate meetings and follow up business items
   iv. Communicate recommendations and planning activities to relevant parties in preparation for the Community Day

III. **Membership**

Membership will include: community members representatives, health facility representatives, stakeholders’ representatives (FBO’s, CBO’s, religious structures, informal leaders, members of associations, etc.), EGPAF Representatives and Regional/District Representatives. The Committee will be comprised of a maximum of 10-12 members, with the ability to accommodate working groups, as necessary. Committee members will act in the overall interests of the community, representing all the structures that the project intends to work with. Committee members will be expected to notify the Chairperson when they are unable to attend meetings.

IV. **Committee Procedures**

1. Meet regularly, maintaining a record of decisions and actions with regards to Community Days.
2. Consult and collaborate with various stakeholders (including other health facilities, community structures, FBO’s, CBO’s and religious structures) at all stages of Community Day planning, implementation and evaluation.
3. Develop organized coordination and communication mechanisms to inform and involve stakeholders, EGPAF personnel, and other relevant structures on the Community Days planning.
4. Support the implementation of the Community Day according to operational plans of the project.
5. Make recommendations to EGPAF and other partners involved on the planning and implementation of Community Days.
6. Provide advice and direction to sustain the implementation of Community Days to EGPAF personnel.
7. Decisions will be reached by an agreed upon consensus as per planning committee membership.
8. Emails and follow-up calls can be used to share information and make decisions outside of regular meeting times as necessary, at the discretion of the Chair. The community health facility representative will be the chair of the committee.
9. A scribe will be elected to record and write minutes, which will be shared with team members and EGPAF prior to subsequent meetings.
I. Purpose

This SOP outlines the process for planning a successful Community Day.

II. Procedures

1. The planning committee will develop a mobilization plan. The following should be done:
   a. Seek audience with community leaders.
   b. Ask community leaders and other influential members of the community to help rally the public.
   c. Identify appropriate media for the audience to be reached—for example, a local radio announcement and use of school children to pass on the word to their parents.
   d. Post announcements in grocery stores, pharmacies or schools in the community.
   e. Invite yourself to various group meetings in the community to get the word out.

2. The committee will develop an implementation plan and the following should be done:
   a. Assign roles and responsibilities for the people who will be of importance during the day’s activities (e.g., master of ceremonies, key speeches, edutainment opportunities such as music, dance, or drama; mobile services).
   b. Assign roles and responsibilities for a sub-group to be in charge of the post-day activities (e.g., writing and disseminating a report, providing feedback to the community, conducting follow-up activities).
   c. Develop a budget (if needed) i.e. money that would be needed to cover all the needed equipment like tent hiring, refreshments, stationery etc.

3. The committee will develop a logistics plan and the following should be done:
   a. Secure the date, i.e. make sure it is suitable for most of the target population (like on a Saturday where most people are not at work).
   b. Secure the venue and ensure that it is accessible to most of the target population.
   c. Brainstorm how to get chairs, tents and other equipment that will be needed for the community day.
   d. Secure the shelter and furniture. If it is a tent or hall make sure it big enough to accommodate the expected population, including furniture.
   e. Secure refreshments and make sure there will be enough food for the expected population.
   f. Set an agenda or program for the day’s activities. Include a conversation trigger and starter conversation, health booths, breakout sessions, small groups reports, and time to reconvene for the facilitated plenary.
   g. Plan other activities for the day (e.g. HIV testing and counselling - HTC, blood pressure checks, blood glucose checks).
h. Invite guests or other people of influence in the community e.g. Member of Parliament (MPs), Regional Health Administrator, Regional Administrator, Representative from chief’s inner council etc.

4. Identify facilitators who should be part of the pre-day meetings:
   a. Identify and select same-gender group facilitator from the community or local health facility. This should be a person with good communication skills who is able to address big masses of community people and has some health background especially in MNCH; it could be someone from MOH, NGO, CBO etc.
   b. Ensure there is at least one health facility staff member or technical resource person on site to answer questions that arise during the day.

III. Resources

1. Form FB1- Committee Member Roster
2. Form FB2-2 Attendance Roster
3. Table 1- Sample Agenda
4. Table 2- Discussion Guide for Maternal and Neonatal Child Health
5. Table 3- Discussion Guide for Adult Women
SOP B-7: Community Day Facilitators’ Recruitment

I. Purpose
The purpose of this SOP is to provide overall guidance on how to recruit Community Day group facilitators.

II. Roles and Responsibilities
EGPAF staff in partnership with the selected committee should:
1. Review the criteria for the group facilitators for women, men and youth groups.
2. Form a recruitment committee comprised of one representative from the DHMT, administrative arm, community health committee (or where there is none, the Village Health Team) each.
3. Convene the PLWHA constituency.
4. Review the roles and responsibilities of the group facilitators.
5. Ensure that recruitment is supervised.
6. Thoroughly document recruitment.

III. Selection Criteria for the Community Day Facilitators
1. Currently reside in the community and familiar with its social structures
2. Fluent in the local language(s)
3. Must be literate
4. Demonstrates strong public speaking skills
5. Has previous experience and/or training as a peer educator, lay counselor, health promoter, or other cadre responsible for community mobilization for health
6. Training and/or experience in health, especially HIV prevention, sexual and reproductive health, MNCH and PMTCT
7. Women and youth must be represented

IV. Procedure
1. Review the criteria with the planning committee and ensure that criteria are fully understood and adopted.
2. Discuss and document the plan and timelines for recruiting the facilitators, including:
   a. Possible local institutions and structures from which facilitators could be recruited
   b. The specific date by which facilitators must be recommended
   c. The date by which all facilitators must be notified of their nomination and screened
   d. The date by which all facilitators will receive orientation on their roles and responsibilities
3. Disseminate the selection criteria within the community structures identified above, including any networks, associations and alliances; communicate the timelines specified clearly.
4. Document the names and contact information of all individuals recommended as facilitators and contact them as soon as possible to confirm their availability and interest.

5. Schedule an information session for all recommended facilitators to receive an overview of the Community Day intervention, their roles and responsibilities and their time commitment. Ensure that there is at least one health facility staff or technical resource person invited to answer questions that arise during the day. Also ensure that two to three members of the planning committee are present and that one EGPAF staff member is in attendance.

6. Conduct an information session with all recommended facilitators who have expressed their interest. At the information session:
   a. Contact details and basic information of all participants should be documented.
   b. Each participant should receive hard copies of the facilitator roles and responsibilities.
   c. One member of the planning committee should review the facilitator roles and responsibilities.
   d. Each facilitator should individually be asked about her/his availability and experience; this information should be documented.
   e. The dates for orienting the facilitators should be announced, and individuals who can attend this orientation session should be identified.

7. After the information session, the recruitment committee should meet briefly to discuss the availability, commitment, experience and adequacy of the candidates.

8. The final list of selected facilitators should be documented and ranked in order of preference.

9. The selected facilitators should be notified and reminded of the technical orientation dates.

V. Resources

1. Form FB3- List of Community Day Facilitators
2. SOP B-1: Roles and responsibilities of the Community Day facilitators
SOP B-8: Conducting the Community Day Facilitators’ Orientation

I. Purpose

The SOP outlines how to conduct the technical orientation for the Community Day facilitators. The technical orientation for Community Day facilitators should take two to three days (depending on the candidates’ experience with HIV prevention, Sexual and Reproductive Health, MNCH, and PMTCT).

II. Roles and Responsibilities

EGPAF staff will ensure that:
1. Participants have advance notice of the date and venue of the technical orientation.
2. Technical resource persons from the health facility, DHMT and EGPAF are identified to lead the sessions of the technical orientation and are formally notified of the dates, their responsibility and any other preparations.
3. Community day participants such as the lay counselors, CHWs, RHMs, etc. are invited to participate when possible.
4. Logistics such as meals, materials and venue arrangements are catered for before the technical orientation takes place.
5. The agenda for the orientation is developed and shared with all resource persons in advance.

III. Procedures

1. Ensure that participants thoroughly complete the attendance register.
2. Conduct introductions and review the agenda with participants.
3. Ensure that the facilitators are introduced to the health facility staff.
4. Ensure that the following content is covered during the orientation:
   a. Overview of the Community Day intervention, its goals and objectives
   b. The roles and responsibilities of the facilitators within the dialogue groups
   c. How to organize the dialogue groups
   d. Review of the dialogue sessions and its thematic content
   e. High-level overview of the technical issues
   f. The importance of socio-cultural themes that should be highlighted and explored within the dialogue groups
   g. How to handle difficult, domineering, withdrawn and skeptical participants
   h. How to identify participants who require referrals for other services
   i. The documentation and reporting activities
   j. Review the data collection and reporting tools
5. Ensure that there is sufficient time for the question and answer session. If questions are not asked by the participants, probe deeply to ensure their understanding.
6. At the end of the technical session, assess the participants for their level of comfort with the technical material and indicate which facilitators will require additional support and exposure to the technical content.
7. At the end of the orientation, the technical resource persons should have a meeting to discuss the participants' learning and identify those who were withdrawn and/or unable to grasp the technical content.

8. During the debriefing session, the technical resource persons should discuss:
   a. What went well
   b. What didn’t go well
   c. Which facilitators are ready for the Community Day event and whether there are sufficient numbers of facilitators for the Community Day
   d. Which facilitators need additional exposure to the technical content and how to ensure their participation in the Community Day to reinforce their skills and knowledge

IV. Resources
   1. Form -FB4-2 Services and referral form
   2. Form-FB4-3A Dialogue facilitator guide
   3. Form -FB4-3B Dialogue facilitator guide
SOP B-9: Community Day Service Planning

I. Purpose

This SOP outlines what health services will be provided during the Community Day. It also outlines how to calculate the staffing level necessary to deliver the services, the logistics and assigning roles and responsibilities to different staff members.

II. Roles and Responsibilities

1. EGPAG staff will ensure that:
   a. A list of the specific services to be provided at the Community Day is discussed by the planning committee.
   b. Implementing partners who could provide the services or support their provision are identified.
   c. Implementing partners who are identified to provide the services are notified and their participation is confirmed.
   d. Planning committee discusses how services should be sequenced and accessed on the day, such as after group dialogues.
   e. Planning committee develops a site organization map that controls the audience’s flow and maximizes auditory and visual privacy.
   f. Ensure that all registration documents will be availed to capture information on services provided to the community.

2. Nurses:
   a. Provide confidential on-site clinical services to the community members. This includes HIV counseling and testing, BP check-up, TB screening, glucose etc.
   b. Provide medication refills if and/as requested
   c. Fill in the necessary registers
   d. Write referral forms for clients who need to be referred to health care facilities
   e. Link HIV positive clients to chronic care

3. Lay counselors:
   a. Provide confidential HIV testing and counseling to the community, including group pre-counseling and individual post-test counseling
   b. Provide confidential couples counseling services as needed
   c. Provide counseling on positive health, dignity, and prevention to individuals who are diagnosed as HIV positive
   d. Provide adherence counseling to individuals who indicate that they are on ART
   e. Record information on approved MOH registers
   f. Write referral forms for HIV positive clients for chronic care

4. Phlebotomist/ lab technicians:
   a. Conduct HIV tests
   b. Conduct glucose tests
c. Collect and safely store biological samples for further processing
d. Process samples that can be processed on-site/at point of care and give results to lay counselor or nurse
e. Ensure that samples that need to be transported to the lab are transported

5. RHMs/CHW:
   a. Manages queues in the service centers
   b. Support registration at service centers
   c. Direct members of the public to service booths

III. The essential services list
1. At a minimum, each Community Day should include the following essential services:
   a. HIV counseling and testing, including collection of DNA-PCR samples for exposed babies
   b. Immunizations
   c. Blood pressure measurement
   d. TB Screening
   e. Glucose testing
   f. Child growth monitoring, including MUAC and/or weights
   g. Nutrition assessment, counseling and support

IV. Procedures
1. The responsible persons on the planning committee should discuss the following needs:
   a. The anticipated attendance numbers, including estimates of the number of pregnant women, children and/or men.
   b. The number of service stations to assemble.
   c. Calculating the staff complement necessary to attend to the participants, including nurses, nurse assistants, VHTs/RHMs/CHWs, lay counselors and expert clients, phlebotomists/lab technicians, nutritionists.
   d. Calculating the number of facilitators required for the dialogue sessions.
   e. Calculating the supplies and equipment necessary for the Community Day.
   f. Timelines for submitting staff and supply requests to the cognizant authorities.
   g. Planning any auxiliary power supply arrangements as needed/appropriate.
   h. Planning the transportation required to ferry staff and supplies.
   i. Planning the safe transportation of biological samples from the Community Day to the clinic and/or the laboratory.
   b. Securing the necessary forms and registrations for referrals, sample transportation, service documentation, etc.
2. Roles and responsibilities should be assigned to:
   a. Supplying tents and chairs for the service booths
   b. Supplying the labor for set up and clean up
   c. Supplying the labor for registration, crowd control and management
   d. Supplying transportation for the ferrying of all supplies, tools and equipment from the health facility to the Community Day venue on the Community Day
   e. Supplying transportation for the staff
   f. Supplying tents, supplies and facilitators for a children's corner
   g. Providing staff to man the service booths
   h. Submitting the staff and supplies request
   i. Planning the safe storage and transportation of the biological samples
   j. Organizing rest facilities and food
   k. Organizing guest speakers and guests of honor
   l. Organizing music, sound, etc.
   m. Producing IEC materials
   n. Contributing branded publicity materials
   o. Local media, public relations, publicity, grassroots and word of mouth publicity

V. Resources
   1. Form -FB4-2 Services and referral form
   2. Form-FB4-3A Dialogue facilitator guide
   3. Form -FB4-3B Dialogue facilitator guide
SOP B-10: Planning for Referrals

I. Purpose

This SOP outlines people who should be referred after testing and why this will be necessary. People who test positive for HIV, people who have high blood pressure and those who have TB symptoms will all be referred to the health facility.

II. Roles and Responsibilities

1. EGPAF Staff should ensure that:
   a. Appropriate forms are supplied and available to capture information on participants accessing services, including service registers and tallies.
   b. There are data collectors or (partners filling in the information) at each service station to capture the summary data.
   c. All summary data sheets collection tools are collected by the end of Community Day and handed over to the Research Coordinator.

2. Program Officer should ensure that:
   a. EGPAF data collectors are trained on the appropriate data collection tools, including the service registers and summary sheets.
   b. Forms are available in each service station to capture the summary data.
   c. The data capture is supervised.
   d. All the registers and summary sheets are collected by the end of the day.
   e. The critical information is stored in a private and locked place.

III. Procedure

1. Register or document all health care services provided to clients in the Ministry of Health (MOH) approved registers.
2. Simultaneously document the names of all individuals receiving healthcare services in the service registers.
3. Complete the summary sheets and provide the appropriate data to the chair of the Community Day planning committee.
4. All HIV positive clients who should be linked into chronic care should:
   a. Complete Pre-ART registers
   b. Be explained the principles of chronic care and what to expect in HIV care and treatment
   c. Be explained the importance of positive prevention to the HIV positive client, and discuss the importance of ensuring that their sexual partner(s) are also tested for HIV, especially if any of their sexual partners are currently present or breastfeeding
   d. If the HIV positive client is a pregnant woman, she should be provided with PMTCT counselling and information on the women’s peer groups
   e. Fill out a referral form and discuss the client’s move to the nearest health facility. Ensure that the client understands:
      i. The main reasons and importance of the referral for the condition(s) or diagnosis and prognosis of the patient
ii. The risks of non-completion of the referral (what could happen if the patient does not follow up on the referral)

iii. How to get to the receiving facility – location and transport, including physical directions to the receiving site

iv. Who to see (name if possible or title/position) and a basic description of what may happen

v. The importance for follow-up on return

f. Secure approval to share the client’s contact information with a CHW, expert clients or lay counsellor who will provide follow up to ensure that the facility referral is completed and explain the follow up window.

g. After the Community Day ends, discuss clear process and procedures for sharing referral information with the receiving facility.

h. After the Community Day ends, discuss clear process and procedures for follow up by the CHWs/expert clients/lay counsellors.

i. Collect information on those referred for participation in peer groups.

IV. Resources

1. Form FB4-2 Services and referral form
SOP B 11- Conducting the Pre-Event meeting

I. Purpose

The purpose of this SOP is to outline the steps that should be taken by the planning committee to make final preparations for the Community Day event.

II. Roles and Responsibilities

EGPAF Staff and the Planning Committee will:

1. Arrive at the Community Day venue early enough for set up.
2. Ensure that there are enough chairs and space for the community members to sit.
3. Ensure that different roles and responsibilities have been assigned to the members of the planning team.
4. Discuss a detailed agenda and logistics plan for the day’s activities with the entire team, including data collection.
5. Check and verify inventory of all the different services and activities of the day.
6. Ensure that adequate IEC materials and supplies are available and people have been assigned roles for distribution.
7. Appropriately cater for logistics for the day.
8. Develop and print a detailed program of the day to be ready for distribution, with an outline of activities to be done, times, and persons assigned to each.
9. Assemble and prepare a team comprised of committee members, group facilitators, trained leaders, and partners for the Community Day.
10. Choose a master of ceremony for the day and orient him on how to carry out his duties during the day.
11. Prepare different speeches for the guest of speakers with key messages. Ensure that every participant is fully registered.
12. Introduce all authorities, partners and the purpose of the day is done participants and facilitators.

The group/peer facilitators will ensure that:

1. All templates and forms have been received
2. The registration forms are completely and accurately filled
3. The exit interview forms are completed as required

III. Procedure

1. Conduct a Pre Event Meeting
   a. Conduct a pre-event meeting, to ensure coordination across partners and to reassign roles and responsibilities if necessary
   b. Present agenda to identified event leader (master of ceremonies) to start the event on time with a short prayer by local pastor. After, introduce a feature presentation, which will serve as a conversation trigger; this could be a short drama presentation (with key messages for the day), movie clip, or audio piece. It is intended to be an entertaining way to start thinking about and discussing the day’s issue.
2. The Conversation Trigger
   a. Give the floor to a feature presentation such as a skit, drama performance, forum theatre, audio narration, or movie clip to present key messages in a format that is accessible and familiar to people. The ideal conversation trigger should be short, impactful, and creative. To avoid conflict and controversy, it should not be politicized.

3. The Starter Conversation
   a. Give the floor to a brief facilitated conversation on the audience’s reactions to open the space for a reflective day. This will be particularly effective if the conversation focuses on the links between the conversation trigger and what participants observe in their communities, peer groups, social circles, and personal lives.

4. The Open Health Booth
   a. Facilitate breakout sessions as are ideal, and, if well facilitated, will allow members from homogenous groups to discuss their perspectives on an issue of importance to the theme or health concerns of the day.

5. The Breakout Session
   a. Set and follow ground rules for participation in the dialogue. Establishing rules helps to create a safe environment for openness and sharing.
   b. Give a brief overview of the identified challenges, as a way to ensure that all participants are on board.
   c. Ask open-ended questions as outlined in the breakout facilitation questionnaire.
   d. Let people deliberate on issues, while you also provide relevant health information and guidance on myths, misconceptions etc.
   e. Document all discussed challenges and solutions to them.
   f. Explore and reflect upon the practices that drive HIV.
   g. Avail yourself after the sessions, as some people may seek you out to ask for advice.

6. Facilitating the plenary and break away sessions
   a. Share the highlights of the breakout, so that there are opportunities for community members to respond to issues of interest to them.
   b. Ask questions and give away prizes like t-shirts, pens, etc. to test the knowledge gained from the breakaway sessions.

7. Closure of the event
   a. Give the participants a chance to talk about the most important thing they gained from the discussion. They should be asked to share any new ideas or thoughts they have had as a result of the discussion and to think about what worked and what didn’t.
   b. Allow participants to explore and plan some concrete, realistically possible actions that they could lead.
   c. Thank the group for taking the time to share ideas and personal values. Ask the local pastor to close the event in a short word of prayer.
IV. Resources

1. Form B5- IEC Materials
2. Form FB5-1 CD Participant register
3. Form FB6-1- Dialogue register
4. Form FB6-2 Dialogue report
5. Form FB7A- Exit Interviews Table 1- Sample Agenda
6. Table 2- Discussion Guide for Maternal and Neonatal Child Health
7. Table 3- Discussion Guide for Adult Women
8. Table 5- Reporting Template
SOP B-12: Setting up on the Community Day

I. Purpose

The purpose of this SOP is to outline the steps that should be taken when setting up the Community Day.

II. Roles and Responsibilities

EGPAF Staff will:

1. Ensure that all members of the planning committee arrive at the Community Day venue early enough for set up.
2. Ensure that the planning committee meets early to review roles and responsibilities.
3. Discuss a detailed agenda and the logistics for the day's activities with the entire team, including data collection.
4. Ensure that adequate IEC materials and supplies are available.

The planning committee will:

1. Spearhead the logistics for the day
2. Complete, distribute and review the detailed program of the day with an outline of activities, times and persons assigned to each to every member of the planning committee.
3. Train the master of ceremony for the day on how to execute his duties.
4. Discuss and finalize the organization map for the day.
5. Finalize the roles and responsibilities,
6. Have the facilitators introduce all of the authorities and partners and discuss the purpose of the day.
7. Meet with the service providers to ensure their set up schedule and needs are met. Agree upon a clean-up schedule and logistics and assign them volunteers from the facilitators/planning committee to ensure that their needs are met.

The group/peer facilitators will:

1. Support any set-up activities as needed.
2. Support participant registration.
3. Complete and accurately fill the registration.
4. Complete the exit interview forms as required.

III. Procedure

1. Set up the following service booths/stations according to the organization map:
   a. HIV testing and counseling
b. Immunizations

c. Voluntary Medical Male Circumcision

d. Screening for potential chronic conditions, including blood pressure measurement and blood glucose testing

e. TB screening

f. Nutrition assessment, counseling and support, including child growth monitoring, MUAC and/or weights

g. Central general seating area

h. Children’s recreation area

i. Rest facilities and hygiene stations

j. Stage or main platform

k. Food stations

l. Power supply system/Generator

2. Setting up the registration points

a. Assign registration responsibilities

b. Set up prominent registration booths

c. Assigning serial numbers to all participants based on time of arrival (for batching the participants at the clinical service stations)

3. Assigning day-of responsibilities for the following:

a. Audience flow and management

b. Trash, including management of bio-waste

c. Production, including managing the schedule and agenda behind the scenes

d. Information, including disseminating IEC materials and responding to participant queries

e. Documentation, including capturing images, video and note taking, with appropriate permission secured and documented

4. Test the public address system, including all microphones and speakers

5. Orientations with the persons responsible

IV. Resources

1. Form B5- IEC Materials

2. Form FB5-1 CD Participant register

3. Form FB6-1- Dialogue register

4. Form FB6-2 Dialogue report

5. Form FB7A- Exit Interviews Table 1- Sample Agenda

6. Table 2- Discussion Guide for Maternal and Neonatal Child Health

7. Table 3- Discussion Guide for Adult Women

8. Table 5- Reporting Template
SOP B-13: Starting the Community Day Festivities

I. Purpose

The purpose of this SOP is to outline the steps that should be taken when starting the Community Day.

II. Roles and Responsibilities

EGPAF Staff will:

1. Ensure that the responsible planning committee members are in attendance.
2. Ensure that the MC, guest speakers and team of facilitators are prepared.

The planning committee will:

1. Set-up activities occur as quickly and efficiently as possible.
2. Resolve and communicate final adjustments to the agenda to the MC.

III. Procedure

1. Approximately half an hour prior to the start time of the Community Day festivities, start the music on the public address system, community mobilization vans or other projection equipment. Run this music until a quorum of community participants is assembled.
2. Once a quorum is assembled, the Master of Ceremonies should warmly introduce himself to the participants.
3. Start the event on time with a short prayer by local clergy.
4. Next, the MC should discuss the agenda for the day and give advice on how to benefit from the services and activities provided throughout the day.
5. The MC should also introduce the chair of the planning committee for recognition, the members of the planning team and the service providers.
6. The registration crew, facilitators, information crew and service providers should be introduced in turns
7. Participants should be shown where to register and get stubs. Registration should be linked to stubs for lunch so that everyone registers.
8. Participants should be pointed to the rest facilities.
9. Participants should be shown how and when to access the service stations.
10. The MC should introduce all guests of honor and allow a short address.
11. The first feature of the day (a drama presentation, movie clip, audio piece, etc.) should be introduced.
IV. Resources

1. Form B5- IEC Materials
2. Form FB5-1 CD Participant register
3. Form FB6-1- Dialogue register
4. Form FB6-2 Dialogue report
5. Form FB7A- Exit Interviews
6. Table 1- Sample Agenda
7. Table 2- Discussion Guide for Maternal and Neonatal Child Health
8. Table 3- Discussion Guide for Adult Women
9. Table 5- Reporting Template
I. Purpose

The purpose of this SOP is to outline suggestions to consider in order managing participant flow when conducting a Community Day.

II. Roles and Responsibilities

The Planning Committee will:

1. Ensure that a group of volunteers (registration crew) is identified to manage registration throughout the day and to provide information (information crew) – in some cases, the registration and information crew may be comprised of the same individuals.
2. Discuss and develop a plan to ensure that the processes and procedures for participants to engage in both the dialogues and service booths are clearly laid.

III. Procedures

1. During event set up:
   a. Assemble a number of the registration and information teams.
   b. Distribute and review venue maps, with clearly labelled stations, to the volunteers.
   c. Discuss the agenda of the day, clearly noting when group activities will occur, and when breakout sessions are scheduled.
   d. Discuss the participant flow from registration → congregation → opening of service booths → opening of dialogue groups → opening of the food station → general congregation → managing exit
   e. Discuss the participant flow between the service booths and the entrance and exit points.
   f. Discuss how to batch participants through the service booths, including the maximum number of individuals that the service booths can hold without substantial queuing and how/whether to handle couples.
   g. Spend a few minutes walking through the venue in order to experience the flow as the participant would.

2. Batching participants through the service booths:
   a. At registration, participants should be given stubs with numbers, which they will use to get lunch. Participants should be pointed to the main service entry point at registration.
   b. The registration team should apprise and update the production team on the numbers of people who have registered for services.
   c. The production team (in charge of the scheduling and agenda) should be in touch with the service stations periodically to track the exit of participants from the service booths.
3. Breakout session
   a. The areas where various dialogue groups will congregate should be clearly marked and identified by the Master of Ceremonies before people break into their dialogue groups.
   b. Volunteers at each dialogue group should welcome participants before they are seated and ensure that participants have selected the right dialogue group.

4. Closure of the event
   a. As the event closes, data collection teams should be stationed at the major entry/exit points to administer the exit interviews.
   b. Allow participants who are selected to complete the exit interviews to do so in a place where they can have auditory privacy.

IV. Resources
1. Form B5- IEC Materials
2. Form FB5-1 CD Participant register
3. Form FB6-1- Dialogue register
4. Form FB6-2 Dialogue report
5. Form FB7A- Exit Interviews
6. Table 1- Sample Agenda
7. Table 2- Discussion Guide for Maternal and Neonatal Child Health
8. Table 3- Discussion Guide for Adult Women
9. Table 5- Reporting Template
SOP B-15: Providing Services on the Community Day

I. Purpose

The purpose of this SOP is to outline issues during the organization of service provision after the Community Day has been kicked off.

II. Roles and Responsibilities

EGPAF Staff will:

1. Ensure that any last-minute logistics and communication needs are identified and resolved during set up.
2. Check off the inventory/checklist of services and activities to verify that all factors have been addressed.

EGPAF Staff will ensure that:

1. All templates and forms have been supplied.
2. Set up is completed promptly.

III. Procedure

1. After the Community Day kick off activities (refer to SOP BX above) have occurred, the Master of Ceremonies should announce the opening of the service stations. Ideally services should be provided when community members arrive, so that there will be no disruptions during the dialogues. Once the dialogues start, all services should be closed.
2. Information crew members should orient participants on the service flow and show them to the appropriate service booths.
3. At each service station, participants should be received warmly. The available services should be explained, and the participants should be assured that the usual confidentiality and privacy expectations apply to the services provided at the Community Day.
4. Service providers should emphasize the importance of truthful and complete responses from the participants, in order to support the best possible health outcomes in the long term.
5. At each service booth, participants should be asked whether or not they have any health records (such as the ANC card, child health record or ART booklet), and if they have registered once directly in the MOH service registers. If participants have any health records in their possession, these tools should be used to verify and validate any information volunteered by the participants.
6. Where results indicate a need for further follow up at the clinic, participants should be given a formal referral in accordance with the procedures outlines in SOP BX – managing referrals. Any issues that may prevent follow through of the referral should be explored and resolutions suggested.
7. After attending one booth, participants should be referred to others, depending on their profile, and reminded of the importance of participating in the dialogue groups.

8. The production team (in charge of the scheduling and agenda) should be in touch with the service stations periodically to ensure that the Master of Ceremonies is informed, on a timely basis, as to when the current batch of registration numbers has cleared the service booths.

IV. Resources

1. Form B5 - IEC Materials
2. Form FB5-1 CD Participant register
3. Table 5 - Reporting Template
SOP B-16: Conducting the Group Dialogues

I. Purpose

The purpose of this SOP is to outline the steps that should be taken when conducting the dialogue groups on a Community Day.

II. Roles and Responsibilities

The Planning Committee will:

1. Ensure that adequate IEC materials and supplies are available and people have been assigned roles for distribution.
2. Ensure that a detailed program of the day is developed, printed and ready for distribution, with an outline of activities, times, and persons assigned to each.
3. Ensure that there are sufficient facilitators and data collectors for the dialogue groups.

The group/dialogue facilitators will ensure that:

1. The dialogue groups adhere to the discussion guides and are spirited and lively without infringing on individual rights to self-expression.
2. Members of the dialogue groups receive the required IEC materials.
3. Members of the dialogue groups are registered by the data collectors.

Master of Ceremony will:

1. Announce that once the service provision is closed all individuals should go to their groups and start the dialogue session.

III. Procedure

1. During the set up:
   a. Each facilitator should identify the team of co-facilitators, data collectors and/or note takers who will support their dialogue group.
   b. The volunteers assigned to each dialogue group should note the physical area where their dialogue group will assemble.
   c. Members of the information crew should look for and proactively approach individuals who appear to be confused or hesitant to join the dialogue groups.

2. Starting the dialogue group:
   a. The facilitator should wait until he/she has a quorum (this should be estimated based on the number of total participants attending the Community Day) before starting the activities of the dialogue group.
   b. When a quorum of participants has assembled, facilitators should introduce themselves and the aim of the dialogue group.
c. Facilitators should encourage participants to introduce themselves if the group is small enough. If the group is large, participants should be instructed to introduce themselves before they contribute to the group discussion or ask a question.

d. Facilitators should set some basic ground rules for participation in the dialogue. These rules should include: Respect for the views of others, all questions are valid, Honesty, Give everyone space and time to express their opinion/make a contribution, Punctuality, Active listening and Participation, Have Fun, Confidentiality, Challenge the idea not the person, Clarify all jargon and acronyms, Use appropriate language free of bias, Do not make assumptions, Use the “Parking Bay” for questions/comments that need further discussion, Cellphones on silent mode or switched off

Establishing rules helps to create a safe environment for openness and sharing.

e. Facilitators should mention that one or several people from the group may be asked to report the deliberations of the group; you should encourage them to pay attention in order to be prepared for executing this function.

3. The dialogue process
   a. Give a brief overview of the identified challenges to ensure that all participants are on board.
   b. Ask open ended questions as outlined in the breakout facilitation questionnaire.
   c. Let people discuss the issues, while you are providing relevant health information and guidance on myths, misconceptions, etc.
   d. Document all discussed challenges and solutions.
   e. Explore and reflect upon the practices that drive HIV.
   f. Avail yourself after the sessions, as some people may seek out you out for advice.

4. Wrapping up
   a. Give the participants a chance to talk about the most important thing they gained from the discussion. They should be asked to share any new ideas or thoughts they now have as a result of the discussion, and to think about what worked and what didn’t.
   b. Ask participants to select one or two people who will report on the discussions and conclusions of the group.
   c. Rehearse the reports.

5. Reconvening in plenary
   a. Explain to participants that a plenary discussion is going to take place, before the day wraps up.
   b. Direct participants to join other participants in the main congregation area.
   c. Remind participants to complete the dialogue registration.

IV. Resources

1. Form B5- IEC Materials
2. Form FB6-1- Dialogue register
3. Form FB6-2 Dialogue report
4. Table 2- Discussion Guide for Maternal and Neonatal Child Health
5. Table 3- Discussion Guide for Adult Women
SOP B-17: Facilitating Community Day Dialogues

I. Purpose

This SOP provides overall guidance on facilitators of the group dialogues at the Community Day event.

II. Roles and Responsibilities

1. The Dialogue Facilitators will lead the dialogues.
2. EGPAF staff will assist in taking notes of the discussion, highlighting key points and issues.

III. Procedures for Facilitating Group Dialogues

1. Establish ground rules for the group. Set a relaxed and open tone.
2. Stay neutral - do not impose personal views or try to advance an agenda on the issue. Facilitate the discussion, don’t join it.
3. Keep track of who is contributing and who is not - Keep the group focused on the content of the discussion and monitor how well the participants are communicating with each other—who has spoken, who has not, and whose points have not yet received a fair hearing.
4. Focus and follow the conversation flow- to help keep the group on topic, it is helpful to occasionally restate the key question or insight under discussion. It is important to guide gently yet persistently. The facilitator might ask, "How does your point relate to the topic?" or state, "That's an interesting point, but let's return to the central issue." It is critical to keep careful track of time.
5. Do not fear silence - it is all right if people are quiet for a while. When deciding when to intervene, err on the side of non-intervention. Sometimes group members need more time to think through alternatives or to consider what has just been said.
6. Accept and summarize expressed opinions-acknowledging contributions shows respect for each participant in the group. It is important for the facilitator to make it clear that day discussions involve no right or wrong responses.
7. Anticipate conflict and attend to the ground rules-when conflict arises, it is important to explain that disagreement is to be expected. It is useful to remind participants that conflict must stay on the issue and must not become personal. It might be necessary to appeal to the group to help resolve the conflict. Stop and refer to the ground rules several times throughout the discussion.
8. Report to the Project Coordinator if there are any challenges or issues encountered.
9. Submit all the forms to the Project Coordinator:
   a. Notes from the group discussions
   b. Community Day Registration Forms
   c. Committee Member Roster
d. General feedback on the discussions and any challenges with the dialogue on an agreed time frame by coordinator/ officer

IV. Resources
1. Form-FB1 Committee Member Roster
2. Form-FB2-2 Attendance Roster
3. Form-FB3- List of Facilitators
4. Table 1- Sample Agenda
5. Table 2- Discussion Guide for Maternal and Neonatal Child Health
6. Table 3- Discussion Guide for Adult Women
SOP B-18: Follow Up Meetings

I. Purpose

This SOP provides guidance on conducting a post event analysis, writing and sharing report of the event.

II. Roles and Responsibilities

The [EGPAF Staff] will be responsible for:

1. Convening the meeting with the planning committee and implementing partners, ideally within one week after the Community Day event was held.
2. Disseminating the agenda prior to the post-event follow up meeting.
3. Ensuring that all elements of the follow up agenda are addressed.
4. Ensuring that a draft Community Day narrative report, data of summary of services and exit interview data are prepared before the stakeholders meeting and are available for review during this meeting.
5. Lead the stakeholders in reviewing the draft Community Day narrative report and exit interview data/feedback.
6. Ensuring that next steps, roles and responsibilities are clearly assigned during the meetings.
7. Taking detailed notes of the follow up meetings and ensuring that these are disseminated to all the participants.
8. Compiling the stakeholder meeting report.
9. Distributing the stakeholder meeting report to all stakeholder in the community.

III. Procedure

1. Conduct a post event meeting with all stakeholders and produce a Stakeholders Report.
2. Meet after two days to review successes and challenges faced during the day. The following questions should guide the discussions:
   
   a. What worked well?
   b. What did not work well?
   c. What was the level of community attendance and participation in dialogues, etc.?
   d. How can future Community Days be improved?
   e. Were the goals of the Community Day met?
   f. What follow-up actions are necessary to ensure that the day achieves sustainable outcomes in this community?
   g. When should the next event be held?
3. Compile and distribute a report within seven days after the event to all community stakeholders, including the D/RHMT (Refer to table 5). This can be done electronically or in hard copy.
4. After the stakeholder report has been compiled, use the information to compile the Community Day Narrative report.
5. In writing the Community Day narrative, consider the following issues:
a. Community leader participation, CHW, partners, stakeholders  
b. Key messages  
c. Number of participants  
d. Use all the registers and forms used on the day to come up with the totals of numbers for attendance numbers, services provided, recruitment of peer and MNCH peer groups etc.  

6. Distribute this narrative to EGPAF management within five days of the compilation of the stakeholder report.

IV. Resources

1. Report RB8-1- Stakeholders’ Meeting Report  
2. Report RB8-2 Community Day Narrative Report  
3. Table 5 – Reporting Template
### Table 1: Sample Agenda

<table>
<thead>
<tr>
<th>Time frame</th>
<th>Item</th>
<th>Responsible party</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00-10:00</td>
<td>Pre-day meeting</td>
<td>EGPASF community linkages team</td>
<td>All partners, NGOs, facilitators, scribes, and resource persons meet to allocate tasks in facilitation, share discussion tools, and so on.</td>
</tr>
<tr>
<td>10:00-10:05</td>
<td>Opening prayer (optional)</td>
<td>Local pastor selected by area chief</td>
<td></td>
</tr>
<tr>
<td>10:05-10:15</td>
<td>Welcome remarks by community representative</td>
<td>Chief’s representative</td>
<td></td>
</tr>
<tr>
<td>10:15-10:25</td>
<td>Why we are here (PMTCT overview)</td>
<td>Assigned health official</td>
<td></td>
</tr>
<tr>
<td>10:25-10:30</td>
<td>Introduction of guests, organizations, services</td>
<td>Master of ceremonies</td>
<td>All guests from partner NGOs, services, and information desks are introduced to audience.</td>
</tr>
</tbody>
</table>
| 10:30-11:15 | Conversation trigger and starter conversation | Drama Group | A drama addressing key MNCH/PMTCT issues: 
- HIV testing and counselling; HIV stigma; discordant couples; lack of disclosure; ART adherence; breastfeeding; partner support in antenatal care |
| 11:15-12:45 | Breakout sessions and concurrent health services provision | 4 facilitators (Boys’ group; Girls’ group; Mothers’ group; Elderly men’s group) | Discussions are guided by the day checklist.
Scribes capture attendance and discussions.
Resource persons address concerns, questions, and myths.
Health services are also concurrently provided but should be controlled to ensure people participate in the different breakout sessions. |
| 12:45-13:15 | Small group reports | Group facilitators | Each small group elects one person to report its summary back to the larger group. |
| 13:15-13:20 | Closing remarks | Chief, member of parliament | |
Table 4: Fact sheet for pre-day planning partners

<table>
<thead>
<tr>
<th>Fact Sheet For Pre-day Planning Partners (Drama Groups, Facilitators, and Speakers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Early enrolment</strong></td>
</tr>
<tr>
<td><strong>Why fathers should attend ANC</strong></td>
</tr>
<tr>
<td><strong>ARV prophylaxis</strong></td>
</tr>
<tr>
<td><strong>Breastfeeding</strong></td>
</tr>
</tbody>
</table>
| **Early infant male circumcision (EIMC)** | The best time to have a child circumcised is between 12 hours and 8 weeks of age.  
Advantages of EIMC: fast healing, no need for sutures and fewer complications (pain, bleeding, and wound gaping) because penis is less developed and child has infrequent erections.  
The penis is made numb by local anesthesia.  
Infants who are eligible for EIMC should be 8 weeks or less, have a birth weight of at least 2.5 kg, not be born premature, be in good health, not have penile abnormalities and not have a family history of blood disorders. |
| **Adult male circumcision** | Benefits: Reduced risk of HIV (60%), improved hygiene, reduced risk of urinary tract infections, prevention or treatment of phimosis, reduced risk of some STIs, reduced risk of penile cancer |
| **On-going support** | Dried blood spot test done at 6 weeks and rapid test given at 12 months to confirm HIV status.  
Children found to be HIV positive are given ARVs right away (half of children not initiated die within the first 2 years of life). |
Table 5 Reporting template

NAME OF CHIEFDOM/COMMUNITY

HEALTH FACILITY

REGION/DISTRICT

ATTENDANCE:

- Women
- Men
- Youth
- Children

ISSUES DISCUSSED AND OUTCOMES

<table>
<thead>
<tr>
<th>Audience</th>
<th>Issue discussed</th>
<th>Outcome/way forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
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<td>Men</td>
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<td>Youth</td>
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<td>Children</td>
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CHALLENGES

LESSONS LEARNED

RECOMMENDATIONS FOR NEXT EVENT

TENTATIVE DATE FOR NEXT EVENT
# FB3-1 Stakeholder Representatives for Planning Committee

<table>
<thead>
<tr>
<th>Stakeholder Institution/Organization Name</th>
<th>Person Nominated for Planning Committee</th>
<th>Sex</th>
<th>Position/Title</th>
<th>Village Name (If Applicable)</th>
<th>Phone Contact</th>
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- **Chiefdom/Ward/Parish/Village Name**: [Blank]
- **Community Day Number**: CD _____-______
- **CD Date**: (dd/mm/yyyy): __/__/__
- **Health Facility Name**: [Blank]
# FB4-1 Community Day Planning Committee Register

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<tr>
<th>Chiefdom/Ward/Parish/Village Name</th>
<th>Community Day Number CD ______ - ______ CD #</th>
<th>CD Date (dd/mm/yyyy): <strong>/</strong>/__</th>
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<th>First Name</th>
<th>Sex</th>
<th>Institution/Organization Name (If None, write None)</th>
<th>Position/Title</th>
<th>Village Name (If Applicable)</th>
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# FB5- 1 Community Day Planning Committee Attendance Roster

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<th>Health Facility Name</th>
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<td>Chiefdom/Ward/Parish/Village Name</td>
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<th>First Name</th>
<th>Sex</th>
<th>Institution/Organization Name (If None, write None)</th>
<th>Position/Title</th>
<th>Village Name (If Applicable)</th>
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</table>
The CD should be built around explaining the CAP and getting the right input, then addressing community barriers.

<table>
<thead>
<tr>
<th>Time frame</th>
<th>Item</th>
<th>Responsible party</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00-10:00</td>
<td>Pre-meeting</td>
<td>EGPAF community day planning committee</td>
<td>All partners, NGOs, facilitators, scribes, and resource persons meet to allocate tasks in facilitation, share discussion tools, and so on.</td>
</tr>
<tr>
<td>10:00-10:05</td>
<td>Opening prayer (optional)</td>
<td>Local pastor selected by area chief</td>
<td></td>
</tr>
<tr>
<td>10:05-10:15</td>
<td>Welcome remarks by community representative</td>
<td>Chief’s representative</td>
<td></td>
</tr>
<tr>
<td>10:15-10:25</td>
<td>Why we are here (This should talk about the CAP, not so much about EGPAF. Maybe the community leader should do this part)</td>
<td>Community Leader</td>
<td></td>
</tr>
<tr>
<td>10:25-10:30</td>
<td>Introduction of guests, organizations, services</td>
<td>Master of ceremonies</td>
<td>All guests from partner NGOs, services, and information desks are introduced to audience.</td>
</tr>
<tr>
<td>10:30-11:15</td>
<td>Conversation trigger and starter conversation</td>
<td>Drama Group</td>
<td>A drama addressing key MNCH/PMTCT issues: Pregnancy and family health; attending all visits Partner support in antenatal care – attending ANC visit but also other support; show how this prevents women from getting proper care if it is not there. Focus on health seeking behavior.</td>
</tr>
<tr>
<td>11:15-12:45</td>
<td>Breakout sessions and concurrent health services provision</td>
<td>4 facilitators (Men’s group; Women’s’ group; Youth’s group)</td>
<td>Discussions are guided by a checklist on the theme of the day and key messages. Scribes capture attendance and discussions. Resource persons address concerns, questions, and myths. Health services are also concurrently provided but should be controlled to ensure people participate in the different breakout sessions.</td>
</tr>
<tr>
<td>12:45-13:15</td>
<td>Small group reports (This should be done in the context of providing input into the CAP)</td>
<td>Group facilitators</td>
<td>Each small group elects one person to report its summary back to the larger group.</td>
</tr>
<tr>
<td>13:15-13:20</td>
<td>Closing remarks</td>
<td>Chief, member of parliament, etc.</td>
<td></td>
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<tr>
<td>Last Name</td>
<td>First Name</td>
<td>Sex</td>
<td>Currently resident in area (Y/N)</td>
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</table>
# FB7-1 Dialogue Facilitator’s Technical Orientation Attendance Roster

<table>
<thead>
<tr>
<th>Chiefdom/Ward/Parish/Village Name</th>
<th>Community Day Number</th>
<th>Health Facility Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD _____ _____ - _____ _____</td>
<td>Meeting Date (dd/mm/yyyy): __ __/ __/ ___ _</td>
<td></td>
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<tr>
<td>CD #</td>
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<tr>
<th>Last Name</th>
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<th>Sex</th>
<th>Institution /Organization Name (If None, write None)</th>
<th>Signature</th>
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</table>
Deliberations – Summary of participant contributions during following segments

- Overview of the project
- Basic Facts on HIV
- Community Dialogue
- Dialogue Facilitation Skills
- Role Plays
- Community Days SOPs

Additional comments or recommendations:

Attach list of participants
FB8-1 Service Package Planning Form

<table>
<thead>
<tr>
<th>Health Facility Name</th>
<th>Community Day Number</th>
<th>CD Date (dd/mm/yyyy):<strong>/</strong>/<strong>/</strong>/<strong>/</strong></th>
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<tr>
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<td>CD ____ _____ - _____ ______</td>
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<table>
<thead>
<tr>
<th>Minimum Services</th>
<th>Name of Service Providers</th>
<th>Material or supplies that need to be catered for</th>
<th>Person/Organization responsible for provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV Testing and Counseling</td>
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<tr>
<td>2. HIV Prevention info/counseling</td>
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<td>3. Blood pressure screening</td>
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<td>4. Glucose screening</td>
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<td>5. Growth monitoring for children (MUAC)</td>
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<td>6. Family Planning</td>
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<tr>
<td>7. TB screening</td>
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<tr>
<td>8. Referrals</td>
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</tbody>
</table>
Other Services to Be Provided:

<table>
<thead>
<tr>
<th>Additional Services</th>
<th>Name of Service Providers</th>
<th>Material or supplies that need to be catered for</th>
<th>Person/Organization responsible for provision</th>
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</table>
## FB12-1 Community Day Health Facility Equipment Inventory Log

<table>
<thead>
<tr>
<th>Health Facility Name</th>
<th><strong>ON ARRIVAL</strong></th>
<th><strong>ON RETURN</strong></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Completed by:</td>
<td>Completed by:</td>
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<tr>
<td></td>
<td>Witnessed by:</td>
<td>Witnessed by:</td>
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<thead>
<tr>
<th>Chiefdom/Ward/Parish/Village Name</th>
<th>Community Day Number</th>
<th>CD Date (dd/mm/yyyy):__ <strong>/</strong> <strong>/</strong> __</th>
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<tbody>
<tr>
<td>CD _____ _____ - _____ _____</td>
<td>CD #</td>
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<table>
<thead>
<tr>
<th>Item/inventory code</th>
<th>Item name</th>
<th>Item description</th>
<th>Quantity</th>
<th>Condition on arrival</th>
<th>Condition on return</th>
<th>Quantity returned</th>
<th>Damage Report</th>
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### FB13-1-CD Participant Register

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<th>Chiefdom/Ward/Parish/Village Name</th>
<th>CD Number</th>
<th>CD Date (dd/mm/yyyy):</th>
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<thead>
<tr>
<th>Name</th>
<th>Sex: M/F</th>
<th>Signature</th>
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<td>18.</td>
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<td>19.</td>
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<td>20.</td>
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</tbody>
</table>
# FB15-1 Referral Form

<table>
<thead>
<tr>
<th>Community Name</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Chiefdom/Ward/Parish/Village Name</td>
<td>Community Day Number</td>
<td></td>
</tr>
<tr>
<td>CD ____ _____ - _____ ____</td>
<td>CD Date (dd/mm/yyyy):__ <strong>/</strong>/__ __ _</td>
<td></td>
</tr>
</tbody>
</table>

1. Client Name: ___________________________      ___________________________
   
   *First*               *Last*

2. Client’s contact number: ______________________

3. Date of Birth: __________________________
   4. Age: __________________
   5. Sex: □ Total Male □ Total Female

6. Services needed: ____________________________________________________________________________________________

7. Name of health facility referred to: __________________________________________________________________________

8. Date to visit health facility being referred to: __________________________________________________________________
## RB15-2 Services Uptake Report

<table>
<thead>
<tr>
<th>Community Name</th>
<th>CD Number</th>
<th>CD Date (dd/mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### Referrals Made (itemize service in rows below):

<table>
<thead>
<tr>
<th>Service</th>
<th>Females 15 years and above</th>
<th>Males 15 years and above</th>
<th>Females Less than 15 years</th>
<th>Males Less than 15 years</th>
<th>Females &lt;24 months</th>
<th>Males &lt;24 months</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Antenatal care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Early infant diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Couples HIV testing and counseling</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>4. HIV care and treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1. Other:</td>
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<tr>
<td>6. Other:</td>
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<td>7. Other:</td>
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</tr>
</tbody>
</table>
**FB16-1 Dialogue Participant Register**

<table>
<thead>
<tr>
<th>CD Number CD _<strong><strong><strong>·</strong></strong></strong></th>
<th>CD Date (dd/mm/yyyy):__ <strong>/</strong> __/ __ __</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Group:</th>
<th>Facilitator Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Name of Village: | |
|------------------||
|                  | |

<table>
<thead>
<tr>
<th>First count</th>
<th>14 years and less</th>
<th>15 years and above</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(≤ 14 years)</td>
<td>(≥ 15 years)</td>
</tr>
</tbody>
</table>

| Second Count | |
|--------------||
|              | |
# Dialogue Template

<table>
<thead>
<tr>
<th>CD Number CD ____ ____ - _____ ____</th>
<th>CD Date (dd/mm/yyyy): __ __/ __/ __ _</th>
</tr>
</thead>
<tbody>
<tr>
<td>GROUP:</td>
<td>FACILITATOR NAMES</td>
</tr>
</tbody>
</table>

## Dialogue Time:
- _______ minutes
- Total Participants_______
- #Males______
- #Females______
- Topics Discussed_______________________

### Deliberations
- Issues that generated more interests in the discussions
- Common myths and misconceptions that were common
- Gaps in knowledge, practices and beliefs
- Areas that need more attention (technical and non-technical)
- Summary of the Discussions
- Questions and answer summary

### Challenges; Recommendations
Exit Interview

<table>
<thead>
<tr>
<th>Date</th>
<th>Community day number</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Place of event/Venue</th>
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<tbody>
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</tbody>
</table>

Respondent Information

AGE: ________________  SEX:  Male ☐ (1)  Female ☐ (2)

1. How did you come to know about this event? (Tick as appropriate)
   ☐ (1) Community leader
   ☐ (2) Radio/newspaper
   ☐ (3) Friend or community member
   ☐ (4) Church
   ☐ (5) Health clinic
   ☐ (6) Mobilisation vehicle with a loud speaker
   ☐ (7) Other (describe)_____________________________________________

2. What were the main message(s) that you heard at this event?

3. What did you like most about this event? Can you tell us why you liked it?

4. Is there anything that you did not like about today’s event? If yes, what and why?

5. Did you use any of the health services offered today? Which ones? (Tick as appropriate)
   ☐ (1) Blood pressure
   ☐ (2) Child weighing/nutrition screening
   ☐ (3) HIV testing
   ☐ (4) TB Screening
   ☐ (5) Pregnancy testing
   ☐ (6) Family planning counseling
   ☐ (7) Other (specify)_____________________________________________

6. Did you participate in one of the group dialogues?  No ☐ (0)  Yes ☐ (1)

7. If yes, was the discussion worthwhile? Why or why not?

8. What could be done to make the next event better?
RB19 Planning Committee Post-Event Meeting Template

Cover page (Community, venue, dates)

Meeting Objectives

Meeting Agenda

Deliberations
- Summary of what worked well?
- Level of community attendance and participation in dialogues, etc.
- How future Community Days could be improved
- Were the goals of the Community Day met?

Challenges
- Summary of what did not work well?
- Logistical challenges

Next Steps (Follow up activities up to CD)
- What follow-up actions are necessary to ensure that the day achieves sustainable outcomes in this community?
- When should the next event be held?

Appendices:
- List of stakeholders with title and institution/organization
RB20 Community Day Narrative Report

- Cover page (Community/, Healthy Facility, District/ Region, venue, dates)
- Table of contents
- CD Objectives
- CD Agenda
- CD Facilitators

Attendance:
- Women................................
- Men.................................
- Youth..............................
- Children.........................

Issues discussed and outcomes

<table>
<thead>
<tr>
<th>Audience</th>
<th>Issue discussed</th>
<th>Outcome/way forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td></td>
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<tr>
<td>Youth (15-24)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
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</tbody>
</table>

Challenges
- Logistical
- Services Provision
- Group Dialogues
- Other

Lessons Learnt
- Logistical
- Services Provision
- Group Dialogues
- Other

Recommendations for next event

Tentative date for next meeting

Appendices:
- List of participants
- Images
- Release Forms
<table>
<thead>
<tr>
<th>Description of IEC material (e.g. Basic facts of EIMC) (This can be contextualized to each country context on the same themes though)</th>
<th>Tally number</th>
<th>Total Number</th>
<th>Name (organization) of distributor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. TB and HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Stop TB in Children</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. IPT: Medicine to help prevent TB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. PMTCT: what you need to know - English</td>
<td></td>
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<tr>
<td>5. PMTCT:</td>
<td></td>
<td></td>
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<tr>
<td>6. Your Child and HIV Testing</td>
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<tr>
<td>7. Understanding your results and planning for the future</td>
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<tr>
<td>8. Real Men Test – “I know my status”</td>
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<tr>
<td>9. How to enjoy sex with a condom</td>
<td></td>
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<tr>
<td>10. Kusoka Kwebesilisa (Male circumcision)</td>
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<tr>
<td>11. PSI Swaziland</td>
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<tr>
<td>12. MC -Champions</td>
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<td>13. Other:</td>
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<td>14. Other:</td>
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<td>15. Other:</td>
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<tr>
<td>16. Other:</td>
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</table>
Good day sir/madam. My name is…………… I am working with the Ministry of Health and the Elizabeth Glaser Pediatric AIDS Foundation to conduct interviews with people who attended this community day event. I would like to talk to you about your experiences and views on this event.

The purpose of this interview is to learn about the perception of the organization, facilitation and activities of the community day from people who attended this event. We will ask you about the knowledge you gained during the event, what you liked most, what you did not like and your suggestions on making this event better in the future. This information will be used to strengthen the manner in which community days are conducted and in which services are delivered during the event.

Participation into the exit interview is voluntary. Your name will not be collected and we will do our best to protect your privacy. All of the information you give us from the interview will be kept private. There are no direct benefits from taking part in this exit interview. We expect that this interview will take about 10-15 minutes.

You may ask us any questions you have at any time or if you have further contributions to provide us you should contact ……………the exit interview coordinator on ……………

**Person Explaining the Interview:** I confirm that I have personally explained the nature and extent of the planned research, exit interview procedures, potential risks and benefits, and confidentiality of personal information to the participant and have answered any questions he/she has. I confirm that the person has voluntarily provided verbal consent to join the exit interview.

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<th>Community Name</th>
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<td>Community Name</td>
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<tr>
<th>Chiefdom/Ward/Parish/Village Name</th>
<th>CD Number</th>
<th>CD Date (dd/mm/yyyy):</th>
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<td>CD ____ _____- _____ ___</td>
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<tr>
<th>Date</th>
<th>Time</th>
<th>Signature</th>
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Participant Number:
FB24-1 Health Service Screening Tally Sheet

<table>
<thead>
<tr>
<th>CD Number CD _____ - _____</th>
<th>CD Date (dd/mm/yyyy):<strong>/</strong>/__ __</th>
<th>Cluster Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Name:</td>
<td>Organization/health facility name:</td>
<td>Name of Chiefdom:</td>
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</table>

<table>
<thead>
<tr>
<th>Health Service</th>
<th>Females</th>
<th></th>
<th>Males</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-24 months</td>
<td>2-14 years</td>
<td>15 years and above</td>
<td>0-24 months</td>
<td>2-14 years</td>
</tr>
<tr>
<td>17. TB Screening</td>
<td></td>
<td></td>
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<tr>
<td>18. BP Screening</td>
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<tr>
<td>19. Sugar diabetes screening</td>
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<tr>
<td>20. Immunization</td>
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<tr>
<td>21. Malnutrition Screening (MUAC)</td>
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</tbody>
</table>

293
Peer Facilitator Guide to Maternal, Neonatal and Child Health for Women

1. Staying Healthy During Pregnancy
   1.1 Introduction, ground rules and programme overview
   1.2 The importance of Antenatal Care (ANC)
   1.3 Understanding what happens during Antenatal Care visits
   1.4 Prevention of sexually transmitted diseases
   1.5 Modes of HIV transmission
   1.6 Preventing HIV transmission from mother to child
   1.7 Staying healthy during pregnancy
   1.8 Sex during pregnancy

2. Pregnancy and Birth Planning
   2.1 Changes in a woman’s body during pregnancy
   2.2 Danger signs during pregnancy
   2.3 Importance of a facility-based birth
   2.4 Reducing risk of HIV transmission from mother to child
   2.5 Developing a personal birth preparedness plan
3. Preparing for Childbirth, Delivery and Immediate Postnatal Care
   3.1 Reviewing your personal birth preparedness plan
   3.2 What to expect during labor and delivery
   3.3 Immediate care for the mother and newborn after delivery
   3.4 Danger signs in the mother after birth
   3.5 Danger signs in newborns
   3.6 Care for your newborn after birth
   3.7 Care for yourself immediately after birth (6 weeks)
   3.8 Importance of exclusive breastfeeding for the first six months
   3.9 Helpful information for successful breastfeeding
   3.10 Myths and misperceptions about infant feeding
   3.11 Reducing risk of HIV transmission during breastfeeding
   3.12 Family planning

4. Staying Healthy After Birth
   4.1 Making a mutual decision about family planning
   4.2 Reducing risk of HIV transmission from mother to baby
   4.3 Nutrition during breastfeeding
   4.4 Good communication to improve family health

Session 1: Staying Healthy During Pregnancy
   1.1 Introduction, ground rules and programme overview
   1.2 The importance of Antenatal Care
   1.3 Understanding what happens during Antenatal Care visits
   1.4 Prevention of sexually transmitted diseases
   1.5 Modes of HIV transmission
   1.6 Preventing HIV transmission from mother to child
   1.7 Staying healthy during pregnancy
   1.8 Sex during pregnancy

Overall session time: 2 hours

Materials needed:
   • Family planning MOH IEC/BCC materials (from health facility)
   • Condom demonstration kits – male and female, if available

SESSION 1.1 Introduction, ground rules and program overview

Learning Objectives:
   • To get an appreciation of EGPAAF work
   • Frame expectations for the classes
• Recognise the value of participation in the full series of Maternal and Child Health classes

Time: 30 minutes

Facilitator Instructions:

• Introduce yourself and let participants introduce themselves. Encourage women to share with the group whether they are mothers and how many children they have, or whether they are currently pregnant and how many months pregnant they are.

• Explain that these sessions will be held biweekly with a duration of 2-3 hours per session, for a total of 4 sessions beginning in early pregnancy and continuing into the post-partum period. Emphasize that it is very important that participants attend all four sessions so that they can learn about ways they can protect their health and the health of their families.

• Set ground rules for the group. Some examples include: participate in all four sessions; share experience when you have it; respect others; it is okay to disagree; if someone shares private information, it should not be shared outside of the group; (need to emphasize). Give examples of confidentiality; don’t talk about personal issues such as HIV status. Allow the group to make some additional suggestions.

Key Messages:

• Welcome. You have been invited to join this programme because you are pregnant.

• This programme is provided by The Elizabeth Glaser Pediatric AIDS Foundation or EGPAF, a non-profit organisation dedicated to preventing pediatric HIV infection and eliminating pediatric AIDS. EGPAF aims to increase community demand, uptake, and retention of Maternal and Child Health services to improve progress toward elimination of pediatric HIV.

• These sessions will help you think through your needs and prepare for a healthy childbirth. You will learn about protecting your health and the health of your baby.

• We recognise that women often have difficulties or face delays in getting care related to pregnancy and childbirth as early as they should, and often face barriers to giving birth in facilities.

• As a participant in this class, please bring your antenatal card that you will be given when you go for your Antenatal Care visit.

Facilitator Note: Remind participants to come to these sessions with their antenatal card. If participants don’t have them, encourage them to go to a health facility and get one.

• Through these classes you will have a chance to learn about: staying healthy during pregnancy, getting the care you and your baby need during pregnancy, birth and postnatal care, and taking care of yourself and baby after birth.

• The sessions will include health talks with time for sharing your own experiences and will help you to find ways to discuss these issues with your partner.

• Similar sessions have been prepared for men in the community to help them better support you during and after pregnancy, and to be a supportive birth attendant.

• The man’s health is also important for your health and your baby’s. Therefore getting your partner in for at least one clinic visit will help ensure the health of everyone.

• In today’s session we will be looking at:
  o The importance of Antenatal Care
  o Understanding what happens during Antenatal Care visits
  o Prevention of sexually transmitted diseases
  o Modes of HIV transmission
  o Preventing HIV transmission from mother to child
  o Staying healthy during pregnancy
  o Sex during pregnancy
SESSION 1.2 The importance of Antenatal Care (ANC)

Learning Objectives:
- Build understanding of the importance of attending ANC and birth preparedness

Time: 20 minutes

Facilitator Instructions

Discussion
- Probing question: What is the importance of ANC?
- Facilitator Note: The services given in ANC will be provided in the next session; this session is about the importance of attendance.
- Review the key messages with participants.

Key Messages
- Antenatal care (ANC) is important because your baby’s health depends on your health and your partner’s health. Early Antenatal Care enables identification of problems that could affect your pregnancy and the health of the baby. ANC can also identify if the birth will be difficult and needs extra support at the health facility.
- Come with your partner to Antenatal Care, as early as possible. You should go to the health facility soon after you have missed your period or suspect you are pregnant – even before your pregnancy is showing!
- It is recommended that you complete at least 4 ANC visits, or more, as recommended by the health care worker.

Facilitator Note: Refer to picture to show number of ANC visits.
- 1st ANC visit is recommended in the 1st trimester (between 1 and 3 months).
- 2nd ANC visit is recommended in the 2nd trimester (between 3 and 6 months).
- 3rd and 4th ANC visit is recommended in your 3rd trimester (between 6 and 9 months).
- Remember to bring your ANC card found in your Antenatal Card to all ANC visits. If you have been pregnant before, bring the card from your last pregnancy.

Facilitator Note: Highlight the importance of keeping the ANC card in the Antenatal Card from the previous and current pregnancy.

Discussion
- Why do women delay their first Antenatal Care visit?
  - Facilitate a discussion on the following questions:
  - 1. How soon do women like to go for their first ANC?
  - 2. What are some reasons that women might wait until very late in their pregnancy before getting their first ANC?
  - What ideas do you have for addressing these reasons for delay?

Wrap-up discussion
- Delaying the first ANC visit can be problematic because if the woman waits to start her Antenatal Care, she may not receive timely advice and medicines from the health facility that can protect her health and the health of the baby during her pregnancy.
SESSION 1.3 Understanding what happens during antenatal care visits

Learning Objectives:
- Increase understanding of what to expect during Antenatal Care visits
- Generate demand for comprehensive package of services; empower women to ask questions about their health care
- Generate demand for early and complete use of ANC and birth preparedness

Time: 20 minutes
Facilitator Instructions
Discussion
- Facilitate a discussion on what Antenatal Care (ANC) provides.
  o What services does Antenatal Care provide?
- Review the key messages with participants and the picture.
- Check with EGPAF staff to know the policy of the health centre in your community – are men welcomed? Are there services that they will provide for the men?
- Be sure that men are not encouraged to come for services that they will not be able to receive.

Key Messages:
- Antenatal Care includes a range of services that are provided to ensure the health of the mother and baby.
- You are encouraged to bring in your partner during at least one of your Antenatal Care visits so that he can be involved in the pregnancy and support you.

ANC visit:
Examination and screening
Facilitator Note: Refer to top left image in 2nd ANC picture.
- Your blood pressure will be taken to make sure there are no pregnancy complications.
- The health care provider will measure your weight and height.
- A physical examination will be done to make sure the baby is growing normally and that your body is ready for a safe delivery, and to listen to the baby’s heartbeat.
- A vaginal (birth canal) exam will be done to show pregnancy progress and any potential complications, checking for any infections or abnormalities. (The health care worker will require you to take off your clothes for a complete physical examination, so you may want to bathe and take concern for proper hygiene ahead of your ANC visits.)
- You will be screened for conditions and infections that can affect your pregnancy including malaria, diabetes, high blood pressure and anaemia. This will include blood and urine tests.
- You will also be tested for possible STIs such as HIV and syphilis. It is best if your partner comes with you and that you are tested for HIV and syphilis together.

Facilitator Note: Refer to bottom image in 1st ANC picture
• If you tested positive for syphilis, you and your partner will be required to take treatment (usually an injection).

• If you are HIV-positive, you will be given counselling and medicine to reduce the risk of transmitting to your baby, and for taking care of your own health. It is important to take this medicine exactly as prescribed. Discuss any questions or problems with your health care provider.

• Be sure that your partner is tested for HIV as well, as there is a risk of infection passing from you to your partner or from your partner to you and your baby during pregnancy and breastfeeding.

Immunizations
Facilitator Note: Refer to top left image in 1st ANC picture.

• You will be given immunizations, including a tetanus shot, to protect yourself and your baby.

Health Education and Counselling
Facilitator Note: Refer top right image in 1st picture.

• Health education and counselling; nurses will ask you questions about your health, including possible sexually transmitted infections, as well as any complications you may have experienced from any previous pregnancies or child births. If you have any existing health problems, such as diabetes, TB, high blood pressure, HIV, problems with past pregnancy, or anaemia, make sure to discuss with your health care provider. In some places you will be given a bed net and malaria prevention tablets.

Supplements will be provided including iron/folic acid.

• At every ANC visit, you should have a physical exam to check for the growth of the baby, listen to the heartbeat, and to check your blood pressure, possible anemia, or other health conditions that might require treatment.

• In the last weeks of your pregnancy, it is important to have the health worker check the position of the baby to make sure that the baby is in the right position for delivery.

• The health worker may also be able to tell you when the delivery is very close.

Probing questions:
1. Why does ANC test for sexually transmitted infections?
2. What are the effects of STIs on women?

Response:
• It is possible to test for and treat certain STIs. Syphilis, chlamydia and gonorrhoea can all be passed on to, and seriously harm, the unborn baby, but they can be tested for, treated and cured during pregnancy. HIV/AIDS, genital herpes, hepatitis B, hepatitis C and HPV (human papillomavirus – which can cause cervical cancer) are caused by viruses but in some cases can be treated with antiviral medications to reduce the risk of passing the infection to the baby, including HIV. Going to ANC provides testing and treatment for these STIs and protection for the unborn baby.

• For every Antenatal Care visit, plan ahead and come with questions for your health worker; you have the right to ask questions and receive explanations when needed.

• Encourage your partner to come along to at least 1 ANC visit. There are services that he should receive to check his health as well.

• Review the ANC visit picture.
SESSION 1.4 Prevention of sexually transmitted diseases

Learning Objectives:
- Understanding the importance of consistent condom use for prevention of STIs
- Understanding the importance of regular screening for STIs

Time: 10 minutes
Facilitator Instructions:
Discussion
- Fears and issues around going to a clinic for testing.

Possible questions:
- What is an STI? What are some STIs that you know? And what are the signs and symptoms?
- Is HIV an STI?
- What STIs can be cured?
- Why might some be reluctant to go to the clinic to be screened for STIs?
- Ensure discussion includes the following messages:
  o Definition: Sexually transmitted diseases (STDs), or sexually transmitted infections (STIs), are generally acquired by sexual contact.
  o The organisms that cause sexually transmitted diseases may pass from person to person in blood, semen, or vaginal and other bodily fluids.
  o Some infections can be transmitted non-sexually, such as from mother to infant during breastfeeding; these include HIV, hepatitis A, hepatitis B and herpes.
  o Generally, the symptoms of STIs (other than HIV) can include:
    o Unusual discharge from the penis, vagina or anus
    o Pain during sex or urination
    o Sores, blisters, ulcers, warts or rashes in the genital area
    o Itchiness or irritation in the genital area
    o Persistent diarrhea
    o Fever or flu-like symptoms
    o Abnormal or unusual vaginal bleeding, especially after having sex
    o Pain in the scrotum or testicles
    o Lumps and bumps on the genitals
- It is possible to test for and treat many STIs, including HIV/AIDS, and reduce the risk of transmitting the infection to the baby.
- Wrap-up by highlighting the importance of going to get tested, especially the benefits of going with their partner. Benefits include mutual support and joint disclosure.
- Review key messages with participants.

Key Messages:
- If you have sex without a condom, you are putting yourself at risk for catching a sexually transmitted infection or disease. It is best to always use a condom and know your status.
• Open sores in the genital area are always serious and need treatment immediately for the safety of the woman, the partner and the baby.

• Symptoms of sexually transmitted infections are not always obvious. In fact you could have a sexually transmitted infection and have no signs or symptoms, but you are still at risk of passing this to others. This is why it is important for you and your partner to go for STI and HIV testing.

• HIV infection usually has no outward symptoms until the disease is well-advanced, so it is important to screen ALL pregnant women and their partners, even if they feel that they are not at risk. By the fact of being pregnant, there has been sexual activity so all pregnant women are at risk.

• You should be screened on a regular basis to identify potential infections and get treated before passing to others. If you think you have a sign of a sexually transmitted infection or have been exposed to one, it is best to get yourself tested at a health care facility.

• Some sexually transmitted infections can be treated easily or eliminated, but others require long-term treatment.

• It is essential to invite your partner to the health facility so that they can also be tested and treated, especially since when left untreated, sexually transmitted infections can increase your risk of acquiring another sexually transmitted infection by viruses but in some cases, including HIV, they can be treated with medications to reduce the risk of passing the infection to the baby.

• HPV (human papillomavirus) is sexually transmitted; it can cause cervical cancer in women and cause complications during birth for mother and baby. In some places, screening for cervical cancer is becoming available and more common. If this screening is offered to you at your health care facility, it is important to receive this screening/exam. You can protect yourself if cervical cancer is found early.

• You can ask your health care worker where this screening is available in your area.

SESSION 1.5 Modes of HIV transmission

Learning Objectives:
• Recognize importance of HIV testing for both partners in relationship
• Understanding mother-to-child transmission of HIV

Time: 10 minutes

Facilitator Instructions:
• Ask the following questions with a show of hands for the following true or false questions:
  o Among couples, one can be HIV-positive and another HIV-negative.
    • TRUE
  o An HIV-positive mother can give birth to a child who is HIV-negative.
    • TRUE
  o A person can get HIV if bewitched.
    • FALSE
  o People on ARVs cannot transmit HIV.
Review the key messages with participants
Make sure participants understand that HIV can be transmitted from an HIV-positive mother to her baby during pregnancy, delivery and breastfeeding.

**Key Messages:**
*Facilitator Note: Refer to image that shows modes of HIV transmission.*

- HIV can be transmitted:
  - Through having unprotected sex with an HIV-infected partner.
  - Through transmission of the virus from an HIV-positive mother to her baby during pregnancy, delivery or breastfeeding.
  - Through the sharing of sharp objects, such as razors and needles, that come into contact with blood of an HIV-positive person, which is a common practice in some parts of the world.
  - Through exposure to HIV-positive blood products.

- Getting tested is the only sure way to tell if you have HIV, protecting your own health and the health of your partner and your child. If you test HIV-negative, you should get retested during your last trimester and during breastfeeding.

- If one partner is HIV-positive, the other partner and child can remain negative.

- It is important to get tested with your partner, as finding out about discordance (when one partner is positive and one negative) is just as important as finding out about your own HIV status. Discordancy occurs where one partner has contracted HIV/AIDS (they are HIV-positive) and the other partner has not (they are HIV-negative).

- If either you or your partner have sex with an HIV-positive person, it can bring HIV into the pregnancy. Getting tested is the first step to protecting your own health and can help prevent infections to partner and child. If you test HIV-negative, re-testing throughout pregnancy and breastfeeding is important because your status can change.

- Recap: Getting tested is the first step to protecting your own health and can help prevent infections to partner and child; re-testing throughout pregnancy and breastfeeding is important as your status can change.

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**SESSION 1.6 Preventing HIV transmission from mother-to-child**

**Learning Objectives:**
- Recognise importance of HIV testing for both partners in relationship
- Understanding mother-to-child transmission of HIV

**Time: 15 minutes**

**Facilitator Instructions:**
- Probing question: Have you heard of PMTCT or preventing HIV transmission from mother to child?
• Response: When a mother is HIV-positive, she can transmit HIV to her child during pregnancy, labor, delivery or breastfeeding; this is called mother-to-child transmission of HIV, or MTCT. There are ways of preventing this transmission, including taking antiretroviral medication (ARVs) and ensuring transmission does not occur during birth by giving birth at a health facility. These measures are called preventing mother-to-child transmission of HIV, or PMTCT.

• Review the key messages with participants.

Key Messages:
• Mother-to-child transmission (MTCT) of HIV, can be prevented through taking medicines (ARVs).
• Early detection and treatment of STIs, including HIV, during pregnancy is important.
• Know your HIV status;
  o If you are HIV-negative, re-testing throughout pregnancy and the breastfeeding period is important, as your status can change and there is a risk of passing the infection to the baby.
  o There is a period of time when a person who has HIV can test HIV-negative because the body has not had time to respond to the HIV yet. After a few weeks, the HIV test will be able to detect the HIV. This is called the ‘window period’. The person actually has HIV but the test doesn’t detect it yet. That is why re-testing is important. The other reason to test is that continued sexual activity during pregnancy could expose you to HIV.
• If you are HIV-positive and pregnant, you should immediately start taking antiretroviral (ARV) medication.

Facilitator Note: Refer to the picture above. This shows 2 key messages: a pregnant woman going with her partner/husband to get an HIV, and the partner/husband supporting the pregnant woman to take her ARVs at the same time every day. Both will prevent transmission of HIV to her child and allow her to breastfeeding when her baby is born.

• All women, regardless of HIV status, should plan to deliver at health facilities with a skilled health care attendant.

Testing:
• Agree to get tested together with your partner so that it is easier to discuss your status with each other and make a plan for keeping the baby protected. It may seem hard at first, but it will make communication about results easier later.
• Discuss with your partner and practice safe sex; use a condom throughout the pregnancy and breastfeeding to avoid HIV infection and other sexually transmitted infections.
• HIV-positive partners need clinical assessment and treatment as advised by the health care worker to reduce risk of transmitting the infection to you and your baby.
• If you can’t get tested at the same time with your partner, agree to a time when you will share your test results with each other.
• If you are starting a new relationship, it is important for both partners to get tested and share their results before starting sex.

Discussion
• Sharing tips on encouraging your partner to get tested for HIV.
• Ask women to share any experiences and tips they have in getting their partners to come to the facility with them.

SESSION 1.7 Staying healthy during pregnancy
Learning Objectives:

- Increase knowledge of healthy practices during pregnancy
- Support women to improve communication around pregnancy related needs and challenges to ensure adequate nutrition, rest and workload

Time: 10 minutes

Facilitator Instructions:

- Refer to the image. Ask peers what it shows. Pick a couple of answers and then review key messages.

Key Messages:

- **Tips for staying healthy during pregnancy**
  - Sleep 6-10 hours each night
  - Rest and relax as much as you can
  - Get help with lifting heavy objects
  - Walk as much as you can to stay fit
  - Wear comfortable clothing
  - Your body needs extra nutrition to support the growing baby. This can be done through eating an extra 1-2 meals each day, and eating nutritious food, even if you do not normally eat them. It is important to eat a balanced diet including proteins (body-building foods), vegetables/fruits (protective – regulating foods) and carbohydrates (energy-giving foods).

- The following foods are particularly nutritious and good for pregnant women:
  - Chicken liver, carrots, cooked greens, pumpkin, mango and other fresh fruit
  - Goat, pumpkin and squash seeds, and peanuts
  - Milk and eggs
  - Beef, liver, and beans
  - Green leafy vegetables (cabbage, spinach, local greens)

- Remember to take vitamins and medicines received from the health care facility including iron supplements, folic acid, and multi-vitamins.

- Avoid harmful substances including alcohol, cigarettes, and non-prescribed drugs and non-nutritional substances like soil.

- Avoid exposure to chemicals (including pesticides) or take precautions such as wearing gloves.

Discussion

- Encourage discussion around challenges and tips for managing diet, rest and workload during pregnancy. Discuss experiences of sharing this with husbands/partners.

- Ask participants about other known harmful practices and ensure you discuss them adequately to correct any false information.
• Myth: A false belief that has surfaced is the idea that women should not eat so much when they are pregnant, so that they do not make the baby too big and have a difficult delivery. This is not completely true. The size of the baby is not so much affected by the amount of food a woman eats; it depends on factors such as the inheritance of the mother and father, as well as conditions such as diabetes and infections in pregnancy. If the man or woman is larger or comes from a family that is larger, the baby may be bigger.

• Misconception: Sometimes in a family, food items such as meat or other protein items are reserved for the men in the family. It is important that these protein items be shared with women while they are pregnant and breastfeeding.

Facilitator Note: Link - In looking at staying healthy during pregnancy, it is important to look also at safer sex practice.

SESSION 1.8 Sex during pregnancy

Learning Objectives:
• Improved communication and negotiation skills in discussing issues related to safer sex, and prevention of HIV, STIs and unintended pregnancy with partners

Materials needed:
• Condom demonstration kits – male and female if available

Time: 30 minutes

Facilitator Instruction:
• Review the key messages with participants.

Key Messages:
• In the last session we looked at staying healthy during pregnancy. Safer sex during pregnancy is also important to you and your baby’s health.
• Having sex is okay during pregnancy, as long as you feel comfortable.
• However, all sex during pregnancy and breastfeeding should take into account safer sex practices such as being faithful and using a condom.
• Discordant couples always need to practise safer sex, such as using a condom.
• Female condoms are also an option for women.
• It is important to discuss the use of condoms during pregnancy and breastfeeding with your partner.
• Avoid sex if:
  o Your water (amniotic sac) breaks or if you are having contractions.
  o There is heavy bleeding, which is a pregnancy danger sign. If this happens, you should seek immediate medical attention.

Discussion
• How can you discuss protected sex with your partner?
• Question: Starting a conversation around protected sex with your partner can be difficult.
Do women have suggestions that could help others to convince partners to use condoms?

- **Wrap-up:** Some examples of successful strategies for engaging men/partners in difficult discussions may include: inviting a respected family member/friend such as an uncle or a grandfather to come speak to your partner, knowing when your partner would be open to such a conversation and making sure you time the conversation accordingly.

**Condom Demonstration**

- Ask participants: ‘Who has seen a condom demonstration before?’

*Facilitator Note: Refer to image – read through following instructions that accompany the image.*

- Encourage a volunteer from the participants to do the demonstration but if a mistake is made, the Peer Facilitator needs to demonstrate the right way!

1. Use a new condom in a sealed packet. Check the expiration date on the packet.
2. Condom package must be torn open carefully, so as not to damage the condom. Fingernails and jewelry can also damage condoms. Use only one condom at a time.
3. Put the condom on after the penis is erect and before any sexual contact. Unroll the condom a little (about ½ inch) and then hold it by pinching the tip with the fingers of one hand.
4. Fully unroll the condom down the entire shaft of the penis to the base. Either partner can do this.
5. Pull the penis out immediately after ejaculation by holding onto the base of the condom first. The condom should be removed away from the partner.
6. The used condom is thrown away. Condoms should never be used more than once.

- In today’s session we talked about:
  - The importance of Antenatal Care
  - Understanding what happens during Antenatal Care visits
  - Prevention of sexually transmitted diseases
  - Modes of HIV transmission
  - Preventing HIV transmission from mother to child
  - Staying healthy during pregnancy
  - Sex during pregnancy
  - In the next session we will cover: issues relating to pregnancy and birth planning – how to ensure both you and your baby are healthy.
  - In the next session we will be working on birth preparedness plans.

*Facilitator Note: Let participants know when and where the next session will be.*

**Session 2 Pregnancy and Birth Planning**

- 2.1 Changes in a woman during pregnancy
- 2.2 Danger signs during pregnancy
- 2.3 Importance of a facility-based birth
- 2.4 Reducing risk of HIV transmission from mother to child
- 2.5 Developing a personal birth preparedness plan

**Overall session time: 2 hours**

**Materials needed:**

- Birth Preparedness Plan

*SESSION 2.1 Changes in a woman’s body during pregnancy*
Learning Objectives:
- Understanding the changes that happen to a woman’s body during pregnancy
- Understanding common discomforts during pregnancy and identifying positive coping mechanisms for common discomforts

Time: 20 minutes

Facilitator Instructions:
- Introduction – welcome back!
  - In our last session we looked at:
    - The importance of Antenatal Care
    - Understanding what happens during Antenatal Care visits
    - Prevention of sexually transmitted diseases
    - Modes of HIV transmission
    - Preventing HIV transmission from mother to child
    - Staying healthy during pregnancy
    - Sex during pregnancy
- In this session we will be looking at: Staying Healthy During Pregnancy.
  - Changes in a woman during pregnancy
  - Danger signs during pregnancy
  - Importance of a facility-based birth
  - Reducing risk of HIV transmission from mother to child
  - Developing a personal birth preparedness plan
- To start we will be looking at the changes in a woman’s body during pregnancy.
- Review key messages with the participants.

Key Messages:
- The baby is growing inside your womb throughout your pregnancy.
- Throughout pregnancy, a woman’s body experiences physical and mental changes; and many women experience social pressures during pregnancy.

Facilitator Note: Refer to picture that shows four stages of development of the fetus in the mother. Remind participants that as the baby develops and changes position, it is important to attend at least 4 ANC visits to monitor this progress.

- A woman’s body produces hormones during pregnancy that help the baby grow, and these hormones can cause emotional changes as well, including mood swings.
- There are a number of minor problems that a woman can have during pregnancy. Most of them can be taken care of within the home; none of these conditions are life-threatening.

Discussion
- Question: What discomforts have you experienced during pregnancy and what can you do to make yourself feel better?
Facilitator should make sure all of the common discomforts presented below are covered in the discussion if the women do not bring up these examples themselves. Facilitator should ask women if anyone has experienced any of the discomforts.

**Facilitator Note: Review common discomforts with picture.**

- **Common discomforts experienced by pregnant women and ways to alleviate them:**
  - MORNING SICKNESS/NAUSEA: Eat smaller meals more frequently, instead of several big meals.
  - HEART BURN: Avoid spicy foods and eat frequent, small meals. Do not lie down immediately after eating.
  - CONSTIPATION: Drink water, eat vegetables and fruits.
  - VARICOSE VEINS: Prop up feet when sitting; avoid standing for long periods of time.
  - HAEMORRHOIDS: Avoid sitting for long periods; eat fruits and vegetables.
  - VAGINAL DISCHARGE: The normal fluids in the vagina tend to increase during pregnancy. This is nothing to worry about unless the discharge becomes greenish, yellowish, or bubbly, and is accompanied by itching or an unpleasant odour, in which case you should seek treatment at a clinic.
  - BACKACHE: Keep back straight when sitting and standing; do exercises. Wear low heeled shoes. Rest should help as well.
  - LEG CRAMPS: Stretch the muscle out slowly by straightening the leg and pointing the toe back. Balance periods of exercise with periods of rest during the day.
  - MILD SWELLING IN ANKLES AND FEET: Avoid tight clothing, shoes, and jewelry. You can relieve swelling by resting on your left side, and elevating your feet several times a day. If the swelling is sudden or if you have swelling in the face, go to a clinic immediately.
  - SHORTNESS OF BREATH: If prolonged, go to a health facility.
  - ABDOMINAL PAIN AND CRAMPING: Drink fluids to prevent the pain. Sit or lie down when the pain strikes. If it is prolonged or does not subside, go to a clinic.
  - URINARY DISCOMFORT: Drink lots of water and urinate often. If there is pain, go to a health facility.
  - HIP PAIN or PELVIC BONE PAIN: Rest and tell a health worker at your next ANC visit. If the pain is severe, seek help at a health facility.

- **Wrap-up:** Referring to the picture, advise peers that any of these discomforts can be responded to at home. Distinguish between common discomforts and danger signs (which are covered in the next topic area) and focus on what can be done to alleviate common discomforts. If any of these problems persist and become excessive, especially vomiting and abdominal pain, advise peers that they need to seek help from a health facility.

**Facilitator Note: You should know what health facilities are near so you can advise the women.**

Check with the women if they know where their nearest health facility is.
SESSION 2.2 Danger signs during pregnancy

Learning Objectives:
- Recognize pregnancy-related danger signs and have a plan to get immediate medical attention

Time: 25 minutes

Facilitator Instructions:

Discussion
- Facilitate a discussion on: Maternal Mortality. Suggested questions to get the discussion started:
  - Do you know any women that have died during pregnancy or childbirth in your communities?
  - What did people say about why they died? What do you think could have been done to prevent these deaths?

Facilitator Note: Myths and misconceptions may be raised during this discussion, respond to them and clarify if they are danger signs, signs of discomfort or incorrect.
- Review the key messages with the picture on danger signs and what they can indicate.

Key Messages:
- Most maternal deaths can be prevented if medical help is received right away.
- While there are many common discomforts that women experience during pregnancy, there are certain signs that indicate danger and require immediate medical attention.
- If you experience any of the following, you need to get help immediately from the health care facility:
  - Very weak and tired, short of breath (can be a sign of severe anemia).
  - Swelling in hands and face is always a danger sign while mild swelling of the feet can be commonly experienced during normal pregnancy.
  - Headache with blurry vision or fits.
  - Severe pain in belly (early in the pregnancy this can be a sign of an ectopic pregnancy, while later in the pregnancy can be a sign of tearing of the placenta).
  - Bleeding from vagina, fluid with bad smell (green or brown).
  - Contractions or rupture of membranes (water breaking) before 37 weeks.
  - Fever (infection).
- While many communities have beliefs about why women die during pregnancy and childbirth, the reality is that there are often medical explanations for complications that could have been prevented if they were recognized and treated on time.
- Danger signs during pregnancy should be taken seriously and you should go to a health care facility immediately, because you and your baby are at risk of losing your lives.
- Do not try to manage these conditions at home, as the help of a professional health care provider is needed to support you and your baby.
- These conditions are not about bewitching and cannot be handled by a traditional healer.
• You need to know where the closest health facility is and how you will get there – it is important to plan ahead and not wait for an emergency.

Facilitator Note: You should know what health facilities are near to advise the women. Check with the women if they know where their nearest health facility is.

Facilitator Instructions:
• Wrap-up: Referring to the picture, if pregnant women experience any of these conditions, they should seek immediate medical attention at a health facility. They are life threatening and cannot be treated at home.

**SESSION 2.3 Importance of a facility-based birth**

Learning Objectives:
• Understanding the importance of a facility-based birth and making a personal commitment to deliver in a facility

Time: 15 minutes

Facilitator Instructions:
• Present picture, and pose a probing question:
  o Why are most women not delivering at a health facility?
  o Why is it important to deliver at a health facility?
  o What do you see in this picture?

• Response to discussion: First address why women do not deliver at a health facility.

<table>
<thead>
<tr>
<th>Issues</th>
<th>Responses</th>
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</thead>
<tbody>
<tr>
<td>Bad perception of health workers</td>
<td>Understand that many are very pressured and overworked</td>
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<tr>
<td>Being used to delivery at home</td>
<td>As discussed in the previous session, even women who have previously delivered with no problems can face critical complications during childbirth for example:</td>
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<td></td>
<td>Women who have given birth many times before often have weakened uteruses that can tear during childbirth leading to life-threatening internal bleeding. The health facilities are equipped to respond to, support and treat both women and their babies during childbirth.</td>
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<td>The placenta may not be delivered or be completely delivered and this causes severe bleeding</td>
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<td>Babies are sometimes born and not breathing, but professionals can help the baby breathe</td>
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<td>Delivery is a time of high risk for life-threatening infections that are dangerous to mother and baby. This can be prevented in a health facility with</td>
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</tbody>
</table>
proper infection control procedures and clean equipment

| Not being able to get/afford transport | Identify possible means of transport to the health facility where you plan to deliver and save enough money ahead of time to pay for it. This will be further covered in session 2.5. |

- Sum-up discussion: Why it is important to deliver at health facility. This picture shows some of the benefits of a facility-based birth including health attendants, clean environment reducing infection, and responding to complications. Also shows the involvement of the man.
- Review the key messages with participants.

**Key Messages:**

- Every woman should have a facility-based birth to protect both the baby and the mother, and precautions should be taken to avoid contact with blood.
- During labor and delivery, life-threatening emergencies for both the mother and the baby can arise quickly that require the help of skilled birth attendants, so it is best to have a plan to deliver in a facility. Whether a pregnant woman has HIV or not, complications such as retained placenta or a breech birth (where the baby comes out feet first) can be life-threatening and are best handled in a health facility.

*Facilitator Note: This picture shows some of the benefits of a facility-based birth including health attendants, and sterile/clean equipment.*

- All women should follow advice received from health care workers, especially HIV-positive women, as it is very important to take medicines, including ARVs, to prevent transmission of infections to the infant.
- Regular health facility visits are important – all women should receive at least 4 Antenatal Care visits, or more, as recommended by the health care workers.

*Facilitator Note: Wrap-up: Emphasize the benefits of a facility based birth so that every pregnant woman should make a commitment to give birth in a health facility.*

**SESSION 2.4 Reducing risk of HIV transmission from mother to child**

**Learning Objectives:**

- Understanding elements of care is necessary to prevent mother-to-child transmission of HIV
- Understanding the importance of HIV testing for the infant and re-testing for the mother during the breastfeeding period

**Time:** 10 minutes

**Facilitator Instructions:**
• Review the key messages with participants.

**Key Messages:**

- **Protect during pregnancy**
  - Mothers with HIV and their infants need extra care to reduce risk of HIV transmission because of mother-to-child transmission of HIV, known as ‘MTCT’. About one in three babies will get HIV from their HIV-positive mothers UNLESS the mothers take ARV drugs. With treatment, the babies are protected and only a very few will get HIV. There may be medicines that an HIV-positive mother and her baby need to take. Option B+ is life-long antiretroviral therapy (ART) provided to HIV-positive pregnant and lactating mothers. It prevents the transmission of HIV from HIV-positive pregnant and lactating mothers to their babies.

- **Protect during childbirth and postpartum**
  - Childbirth is the time of the highest risk of HIV transmission from mother to baby because of the increased exposure of the infant to the mother’s blood and body fluids. It is important for mothers to give birth at health facilities as they are equipped to prevent the transmission of HIV from mother to baby. Infants born to HIV-positive mothers should take NVP syrup (NVP is an antiretroviral drug) during the first six weeks of life to provide additional protection against HIV at this critical time.

- **Protect during breastfeeding**
  - Irrespective of the mother’s HIV status, the baby should be given only breast milk for a period of 6 months, with exception of medications prescribed by a health care worker.
  - If the mother has HIV, she can breastfeed as long as she and her baby are taking antiretroviral (ARV) medication.
  - After 6 months, the baby will need more nutrition. The mother should add additional foods and continue to breastfeed.
  - If the mother and baby are taking their medications and following the advice of the health care worker, the risk of HIV transmission through breastfeeding is very small. Breastfeeding allows the baby to get the important benefits of breastfeeding and breast milk.
  - If the baby becomes infected, initiate ART as soon as possible to prevent life threatening infections and to keep the baby healthy.

- **Emphasize:** Make sure participants understand that mixed feeding increases the risk of mother-to-child transmission of HIV. The baby’s gut is very delicate and giving food too early creates opportunities for infection.

- **HIV testing for you, your partner and your baby**
  - Even if you are HIV-negative, HIV re-testing is important for you and your partner throughout breastfeeding after resuming sex to lessen the risk of HIV transmission to the baby.
  - It is important to use a condom when having sex throughout the duration of breastfeeding to prevent HIV infection and other sexually transmitted infections.
  - At six weeks your baby should receive an HIV test by putting drops of blood from the baby’s heel onto a special paper. It is important that you get the results from this test. If a baby is HIV-positive on this test, urgent ART treatment can not only save the baby’s life but also ensure it has a healthy life.
  - For those who test negative, the HIV test should be done again 6 weeks after the cessation of breastfeeding or at 18 months. It is important that you take your baby to these HIV tests.
  - Where available, you can join a family or mother support group at a local health facility where it is possible to get helpful advice about infant feeding as well as support for parents living with HIV.
Facilitator Note: Peer facilitators should find out if/where there are family support groups and refer the peers to them.

Facilitator Instructions:

- Discussion
- What should a mother and father do in case:
  - Neither have HIV
  - Mother has HIV
  - Mother does not have HIV but the father does
- Recap: Make sure participants understand that mixed feeding increases the risk of mother-to-child transmission of HIV.

Facilitator Note: Review picture and emphasize the need from women to get tested with their partner and, if HIV-positive, to ensure they take ARVs during pregnancy and breastfeeding to ensure they do not transmit HIV to their baby.

SESSION 2.5 Developing a personal birth preparedness plan

Learning Objectives:

- Understanding the importance of a facility-based birth and making a personal birth preparedness plan

Time: 40 minutes

Facilitator Instructions:

- Introduction: We have discussed the importance of a safe delivery and some of the complications and dangers that can arise during pregnancy and childbirth.

Facilitator Note: Make sure that you have discussed with the EGPAF staff about the readiness of the facility to receive additional women for facility deliveries. You may be able to arrange to have a midwife come to discuss this with your group if it is requested.

Discussion

- Addressing barriers to a facility-based birth
- Questions:
  - What are some of the challenges women face in getting support during pregnancy?
  - What challenges do women face with seeking a facility-based birth?
  - Share experiences on preparing for a delivery.
- Wrap-up discussion, connecting the challenges of getting support during pregnancy and challenges of accessing a facility-based birth with the need to prepare, and the role of the Birth Preparedness Plan.
- Recommend that all participants have a Birth Preparedness Plan. Instruct participants that their task following this session will be to take these forms home and use it as a tool to make a plan with their partners or a family member on how they will arrive to the facility for their delivery.
• Review the key messages with participants.

*Facilitator Note: Have a handout with a blank birth preparedness plan as many women will not have the Birth Preparedness Plan in this session. Refer to the Birth Preparedness Plan as you go through the key messages.*

**Key Messages:**

• Sometimes women have challenges getting the support they need to prepare for a facility-based birth. It is important that you start these discussions with your partner or another family member early to give yourself enough time to prepare.

• A full Birth Preparedness Plan helps the mother and father to prepare adequately for a safe birth. *Facilitator Note: Refer participants to their birth preparedness plan if they have brought them.*

• A full birth preparedness plan requires the following elements:
  - Where do you intend to deliver?
  - How will you get to maternity services? If needed, what emergency transport options are available in your community?
  - If your community has an emergency transport system, let them know you are pregnant and make sure you have a contact number to reach them in case of an emergency.
  - How much money do you need to save to cover costs, including transport, health center fees, and food?
  - Where is the closest maternity hut/home nearby the health facility? Do you have a family member nearby where you can stay?
  - Who will provide childcare for other children in the family during your delivery?
  - Do you need to save money for childcare during your labor and delivery?
  - Who will support you during labor and delivery?
  - If you experience any of the danger signs during pregnancy or if the birth comes early, how will you get to the health facility? What happens if you are away from home at the time of labor and delivery?
  - The health workers at maternity will need to know the HIV status of the mother in order to take extra precautions during the birth to prevent mother-to-child transmission of HIV. Do you know your status?
  - If placenta disposal is important to you, you should talk to the midwife at the facility.

• What do you need to bring for yourself and baby (hat, blanket, nappies, etc)?
  - For the baby: Baby blanket, towels, nappies, baby clothes.
  - For the mother: sanitary pads, toiletries, clothes, blanket.

• Currently many health facilities that conduct deliveries have supplies to support mother and baby such as gloves, cotton wool, soap, towels, mackintosh, etc. The supplies available will vary depending on the health facility. Where possible, check to see what the health center you are planning to go to will provide.

**Homework**

• Go home and discuss the birth preparedness plan with your spouse and/or a family member. In the following sessions there will be a recap on the issues identified as you fill the birth preparedness card. *Facilitator Note: Remind participants to bring their Birth Preparedness Plan to the next session if they are able and willing to.*

• In today’s session, we covered:
  - Changes in a woman during pregnancy
  - Danger signs during pregnancy
  - Importance of a facility-based birth
  - Reducing risk of HIV transmission from mother to baby
  - Developing a personal birth preparedness plan

• In the next session we will cover: preparing for childbirth, delivery and immediate postnatal care.
Session 3 Preparing for Childbirth, Delivery and Immediate Postnatal Care

3.1 Reviewing your personal birth preparedness plan
3.2 What to expect during labor and delivery
3.3 Immediate care for the mother and newborn after delivery
3.4 Danger signs in the mother after birth
3.5 Danger signs in newborns
3.6 Care for your newborn after birth
3.7 Care for yourself immediately after birth (6 weeks)
3.8 Importance of exclusive breastfeeding for the first six months
3.9 Helpful information for successful breastfeeding
3.10 Myths and misperceptions about infant feeding
3.11 Reducing risk of HIV transmission during breastfeeding
3.12 Family planning

Overall session time: 2 - 3 hours

SESSION 3.1 Reviewing your personal birth preparedness plan

Learning Objectives:
- Understanding the importance of a facility-based birth and making a personal commitment to deliver in a health facility
- Improved communication with partners around difficult topics, including planning for a facility based birth

Time: 15 minutes

Facilitator Instructions:
- Introduction: Welcome back!
- In today’s session we will be going through the following content:
  - Reviewing your personal birth preparedness plan
  - What to expect during labor and delivery
  - Immediate care for the mother and newborn after delivery
  - Danger signs in the mother after birth
  - Danger signs in newborns
  - Care for your newborn after birth
  - Care for yourself after birth (6 weeks)
  - Importance of exclusive breastfeeding for the first six months
  - Helpful information for successful breastfeeding
  - Myths and misperceptions about infant feeding
  - Reducing risk of HIV transmission during breastfeeding
Family planning

In our last session we looked at: pregnancy and birth planning and you were asked to discuss the Birth Preparedness Plan with your spouse and/or family member.

Discussion

- Participant experiences with developing a personal birth preparedness plan

Suggested questions to start the discussion:

- Since our last session, were you able to develop a birth preparedness plan with your partner or another family member?
- How did you find the discussion with partner or other family member – was it easy or difficult?
- If you live far from the health facility, what options did you find for either maternity waiting rooms, or family/friends close by to the facility where you plan to deliver your baby? Who will take care of your other older children when you go to the facility to deliver your baby?
- What will you do if labor starts before you expect it to, or if you have a danger sign?

- Recap: Review key items shown in the picture – these items are useful and it is wise to ensure participants have them ready for the birth.

- Review key messages with the participants.

Key Messages:

- Every woman should have a facility-based birth to protect both the baby and the mother, and precautions should be taken with blood and body fluids.
- Making a birth preparedness plan helps to ensure that you and your partner are prepared for a facility-based birth.

SESSION 3.2 What to expect during labor and Delivery

Learning Objectives:

- Recognizing signs of labor and putting in action the personal birth preparedness plan to arrive at the facility for delivery after labor begins
- Knowing what to expect during labor and delivery and ways to stay comfortable during labor and delivery

Time: 15 minutes

Facilitator Instructions:

- Lead a discussion on sharing tips for staying comfortable during labor and childbirth. Start with the points in the module: eating small meals, drinking, walking around, and breathing through labor pains. Open out to participants for discussion.
- Probing question: What was your experience of labor, delivery, and what happened to you immediately after delivery (what care was given to you and your baby immediately after birth)? How did you cope?

Facilitator Note: Women may be compelled to share stories about negative experiences at health care
facilities, especially during labor and delivery and may want to talk about their preference for home births. It is important for the facilitator to recognize the reality that some women have had negative experiences but that cannot outweigh the benefits of health facility delivery. Acknowledge that the birthing process can be highly stressful for BOTH the women and the health care worker and that health care workers are doing their best to ensure a safe pregnancy and delivery.

- Emphasize: The importance of ANC and facility-based birth, and knowing what to expect when receiving services helps the women be better prepared.
- Discuss the key messages with participants.

Key Messages:

- When labor begins, it is time to go to the health care facility immediately. Health centers III and above provide maternity services. For those women who live far away from the health facility, it is recommended that you go to the maternity waiting rooms or a family/friend’s home near the health facility when you are at the end of your pregnancy, (9 months pregnant). Your expected date of delivery will be given to you when you go to Antenatal Care (ANC).
- Labor begins when contraction pains are regular and the same amount of time passes between each one. Other signs of labor include a gush of clear water from the vagina; clear or pink mucus from the vagina; and contraction pains.
- When you arrive at the health care facility you can expect health care staff to do a vaginal exam to check how far your cervix has dilated, check the heart rate of the baby, and use a partogram, which measures the progress of your labor. You may want to ensure personal hygiene and wash before going into the health facility. The health care worker will also watch your temperature and blood pressure, as well as continue monitoring you for danger signs.
- Be sure that you have brought the materials that you need during your time in the clinic.
- Bring someone to support you during delivery.
- Advice during labor:
  - During labor, it is ok to eat small meals, drink when you are thirsty and walk around for comfort. Walking around can also help labor to progress faster.
  - It is important to keep breathing through labor pains.
  - Never push before the health care worker tells you to do so. Doing so before you are told to do it will put your life and that of your baby at risk.
  - Give birth in the best position for you. Before you need to push, talk with the health care worker about what positions will be possible for you to deliver and what will be most comfortable for you.

Facilitator Note: This picture shows a mother giving birth in a health facility. In the facility, the health staff can monitor her, help ensure a safe birth and place the baby on her chest after birth so that her baby can start breastfeeding.

- Avoid taking herbs and unprescribed medicines as they can be dangerous to you and the unborn baby.
- Probing question: Are there herbs or traditional medicines that women use in preparation for birth?
- Response: These can be harmful to the baby and the mother and should be avoided.
SESSION 3.3 Immediate care for mother and newborn after delivery

Learning Objectives:
- Understanding the importance of infection prevention during delivery, and post-delivery care for the mother and newborn
- Understanding newborn care and the importance of early breastfeeding

Time: 15 minutes

Facilitator Instructions:
- Review the key messages and picture with participants.

Key Messages:
- After the baby comes, s/he will need to be immediately warmed and dried; skin to skin contact between the mother and the baby is important for warming the baby.

Facilitator Note: Refer to picture, reinforce the importance of immediate breastfeeding.

- The baby should be placed on the breast within the first hour of delivery as the first milk is full of important vitamins and nutrients for the baby – the early yellow milk is good for the baby and should not be discarded! The gut of the newborn is very delicate, breast milk is the best thing for them!
- Provides protection to the baby, protects him/her from viruses, infections and illness.
- Immediate breastfeeding also benefits the mother:
  - Encourages bonding between mother and baby
  - Stimulates continued production of breast milk
  - Facilitates the delivery of the placenta (after-birth)
  - Helps contraction of uterus
- After the placenta comes – you will be watched for warning signs including excessive bleeding and signs of infection or toxemia.
- It is important to you and your baby’s health to have a facility-based birth, but if you have an unexpected home birth or give birth before you arrive at the facility – it is extremely important to prevent life-threatening infections to you and your baby:
  - Anyone helping you with the delivery or handling the baby should wash their hands thoroughly with soap and clean water.
  - You should use a new razor for cutting the cord of your baby.
  - Wrap your baby and the cord in a clean cloth. There is no need to wash your baby immediately – they are born with a protective layer that will be absorbed into and protect the baby’s delicate skin.
  - You need to get to a facility immediately, as soon as possible, no later than 24 hours so that you and your baby can be examined
- Following the birth, keep the baby’s skin, cord stump and eyelids clean. The best way to clean the baby’s cord is to apply a mixture of cool boiled water and salt to the base of the umbilical cord’s stump, where it meets the baby’s stomach. Do not clean or interfere with the umbilical cord itself.
Facilitator Note: Emphasize that women should not use anything else to clean the umbilical cord stump – herbs, cow dung, soot, spit, soil and other home remedies actually cause infection.

- Examine your baby’s body carefully at least once a day to check that there is no rash, infection, etc.
- The fontanel, where the baby’s head is soft at the top, will close on its own; there is no need to do anything special. Trying to ‘shape’ the baby’s head will only traumatize the head. The front fontanel will close around 4 – 5 months and the back, after 6 weeks.
- Probing question: What is traditionally done to close the fontanel?

Facilitator Note: The discussion will bring out issues (prompt if not given) including giving of herbs, and tying beads around the baby’s neck. The Peer Facilitator should discourage these traditional practices and emphasize they are harmful to the baby; also emphasize that the babies should be given breast milk to avoid dehydration.

- Keep sick people away from your baby.
- If the baby feels cool – make skin-to-skin contact, cover head and body, and breastfeed often.
- If the baby feels warm – stay with your baby in the coolest part of your home, loosen baby’s clothes, and bathe in lukewarm, not cold water. Dry well and breastfeed often.
- Probing question: What is traditionally done in response to rashes on the newborn?

Facilitator Note: Issues include (prompt if not raised) use of herbs to wash or treat the baby. The Peer Facilitator should dispel this practice. If the baby has a rash, if it often a heat rash caused by overheating; babies do not sweat. Take his/her temperature with the back of your hand. Adjust what you wrap the baby in. If the rash persists, take your baby to a health facility for professional health care.

SESSION 3.4 Danger signs in the mother after Birth

Learning Objectives:
- Recognizing danger signs after delivery and empowering women to seek immediate medical attention if they experience any danger signs

Time: 10 minutes

Facilitator Instructions:
- Re-cap: We looked at care for mother and baby immediately after delivery. We are now looking at danger signs and care after delivery, when mother and baby are back at home.
- Review the key messages and picture with participants.

Key Messages:
- Get help from the nearest health facility immediately for any of these:

Facilitator Note: Refer to the picture as you review the following danger signs.

- Severe pain in the lower belly
- Swelling in face or hands
- Heavy bleeding – do not wait if there is very heavy bleeding. Bleeding should become less and completely stop by two weeks after birth.
- Severe headache, vision problems; fits
- Fainting or extreme weakness
- Fever
- Bad smell from the birth canal
- Hot, red or painful lump in breast
- Leaking urine or faeces
- Cannot pass urine
- In case of an emergency homebirth, if the placenta or afterbirth does not come out within 10 minutes of giving birth, seek immediate attention. The mother needs to go to the health facility immediately if she is not already there.

Facilitator Note: Emphasize importance of a facility-based birth.

- Mood changes after birth are normal. This is most often related to hormones (your body’s natural chemicals that change during and after pregnancy, and not bewitching). Postnatal depression affects many mothers and is not something to be ashamed of or hide. If it does not go away, it is a problem, may be postnatal depression, and needs attention from a trained health professional.
- If you feel you may hurt yourself or your baby, you need urgent help from a health worker.

SESSION 3.5 Danger signs in newborns

Learning Objectives:
- Understanding basic care to keep the baby healthy after birth
- Recognizing danger signs in an infant and empowering women to seek immediate medical attention if the baby experiences any danger signs

Time: 10 minutes

Facilitator Instructions:
- Flip chart/group discussion around care tips and warning signs.
- Review key messages and picture with participants.

Key Messages:
If you notice any of the following signs or suspect something is not right - get help! Keep breastfeeding, and keep your baby warm and dry.

Facilitator Note: Refer to picture as you review danger signs.

Danger Signs:
- Feeding difficulties or refusal to breastfeed (can’t suck, weak sucking, stops feeding too soon)
- Excessive vomiting, diarrhoea or fever
- Little energy (not active, not feeding, moves only when touched, limp)
- Baby too hot or cold
- Breathing difficulty (breathes slowly, nostrils widen, breathing fast, skin around ribs draws in)
- Fits or convulsions (jerky motions)
- Yellow eyes or skin
- Infected belly button, eyes or skin
• Bulging fontanel (soft area of baby’s head – do not try to shape but bring your baby to a health facility)
• Cannot pass urine or feces

SESSION 3.6 Care for your newborn after birth

Learning Objectives:
• Understanding the importance of postnatal care for the newborn

Time: 10 minutes

Facilitator Instructions:
• Looking at the picture, review the key messages with participants.
• Emphasize the importance of early PNC visits (contextualize based on your country guidelines):
  o At 6 hours and 6 days to check both mother and the baby.
  o At 6 weeks to begin the child’s immunizations.

Key Messages:
• Following the birth of your baby, there is a whole schedule of health care facility visits for the first five years that are essential for ensuring healthy growth and development.
• These visits are more frequent in the first two years, especially the first six months:
  o The 1st recommended visit for the mother-baby pair is within the first 24 hours. If you do not give birth in a facility, be sure to bring your baby to the facility for this important visit. Most newborn deaths occur within the first 24 hours of life.
  o The 2nd visit should happen within the first seven days after delivery for all mothers and babies.
  o The 3rd recommended visit is 6 weeks after delivery when the immunizations begin. Thereafter, the visits follow the routine immunization schedule. You may need additional visits if your baby has been born early or with any other birth complications. You should follow advice you receive from the health worker.
• Services received during visits include immunizations, growth monitoring, and developmental assessment of the child, checking for health problems, and testing for HIV infection.
• The child will receive an immunization card that should be kept clean and up to date; this will be necessary for school enrolment for the child. When you go to the clinic, make sure you bring your baby’s health card and yours.
• Discuss circumcision of male infants with your partner and the health care worker. Male circumcision is one way of reducing the risk of future HIV infection in sexually active men. Between 7 and 28 days after birth is the recommended time for male circumcision.
• You should follow the recommended visit schedule and take all medications as prescribed; follow the advice of health workers received during these visits.
• Ask if anyone has any concerns and talk through them, emphasising the benefits of postnatal care (PNC) key messages.
SESSION 3.7 Care for yourself immediately after birth (6 weeks)

Learning Objectives:
- Understanding what to expect as your body heals after the birth

Time: 5 minutes

Facilitator Instructions:
Discussion
Start a discussion around healing in the first 6 weeks after giving birth. What can cause infections of the womb?

- Myth: Some women insert herbs and snuff into the vagina because they believe that it enhances enjoyment for men during sex.
- This can scrape the vagina, causing infections and increasing the likelihood of contracting HIV and other diseases among women.
- Misconception: There is pressure on women to resume sex after 4 days. At this time your womb and birth canal are still healing and therefore prone to infections. It is important to wait 6 weeks after birth before resuming sex.

Review the key messages with participants and the picture that relates to 4 key messages.

Key Messages:
- After birth a woman continues to bleed until the uterus heals completely; bleeding can occur in the 1st and 2nd week following delivery, and gradually reduces as the uterus heals. If bleeding is heavy (it fills more than 3 pads in 30 minutes) or it continues after 2 weeks, the woman needs to go to the health facility.
- After delivery it is important to avoid life-threatening infection of the womb and the birth canal.
- Nothing should be placed into the vagina until all bleeding stops, including no sex for the first six weeks.

Facilitator Note: The picture shows that the womb (uterus) and birth canal (vagina) is traumatized and inflamed during birth. This area takes 6 weeks to recover and return back to normal.

- This is why the six week visit to the health care facility is important – the midwife or health care workers needs to examine you to ensure your womb has healed and returned to normal.
- During these visits, the health care worker will conduct a vaginal examination. Women may want to wash before these visits.

SESSION 3.8 Importance of exclusive breastfeeding for the first six months
Learning Objectives:
• Understanding the importance of early and exclusive breastfeeding for the first six months of the baby’s life

Time: 10 minutes

Facilitator Instructions:
• Group probing question: What are the benefits of breastfeeding?
• Review the key messages and picture with participants.

Key Messages:
• All babies need early and exclusive breastfeeding for six months irrespective of the mother’s HIV status – no other liquids or foods should be given to the baby during the first six months.

Facilitator Note: Refer to picture; this picture shows a mother exclusively breastfeeding her infant for 6 months.
• All mothers can produce enough milk of good quality for their babies
• Starting early and feeding frequently are key ways to ensure a good milk supply.
• Benefits of breastfeeding:
  o Breast milk is full of important vitamins and nutrients for the baby – the early yellow milk is good for the baby and should not be discarded! The gut of the newborn is very delicate, and breast milk is the best thing for them!
  o Breast milk provides protection to the baby, protecting him/her from viruses, infections and illness.
• Immediate breastfeeding also benefits the mother:
  o Encourages bonding between mother and baby
  o Stimulates continued production of breast milk
  o Facilitates the delivery of the placenta (after-birth)
  o Helps contraction of uterus
• If a woman is HIV-positive, she can prevent passing the HIV virus to her baby by taking medicines called Antiretroviral Therapy (ART) while pregnant and lactating. In many countries, ART would continue to be taken for life.
• For the first six weeks after delivery, you need to stay healthy. Continue to rest daily, drink plenty of liquids and eat extra foods from each food group during the entire time you are breastfeeding.

SESSION 3.9 Helpful information for successful breastfeeding
Learning Objectives:

- Understanding how to breastfeed successfully

Time: 10 minutes

Facilitator Instructions:

- Review the key messages and picture with participants.

Key Messages:

- You should feed the baby on demand, at least every 3 hours, day and night, especially during the first few months.
- Proper position of your baby on the breast and the baby attachment to the breast is important for success: you should place your baby chin to breast, chest to chest, and the baby should have more than the nipple in the mouth. Sit in a comfortable position, and keep trying!

Facilitator Note: Refer to picture; this shows proper attachment and positioning for breastfeeding. Let participants know that if they have trouble getting newborns to breastfeed, they can get advice and support from the health facility.

- Always visit your health care worker if there are any issues with breastfeeding.
- Expressing milk if you are away from your baby
  - If you need to be away from the baby, you can express the breastmilk by hand. Make sure you wash your hands with soap and running water before expressing the breastmilk and make sure the cup or vessel you will use to collect the breastmilk has been cleaned and boiled to ensure there are no germs or bacteria.

Facilitator Note: Do not use bottles with teats; they collect bacteria and are unhygienic.

- The expressed breastmilk should be stored in a cool place for 6-8 hours, or in the back of the refrigerator for up to 3 days.
- The person feeding your baby while you are away should use a cup and place the cup on the baby’s bottom lip and allow the baby to take small amounts of milk. Do not pour the milk into the baby’s mouth. Bottles are unsafe to use because they are difficult to wash and can be easily contaminated.

SESSION 3.10 Myths and misperceptions about infant feeding
Learning Objectives:
• Empowering women to exclusively breastfeed infants for the first six months
• Recognising that not all advice is friendly advice, even from relatives or close friends

Time: 15 minutes

Facilitator Instruction

Discussion
• Facilitate a discussion on exclusive breastfeeding.
  o What are examples of advice or pressure that mothers receive regarding care of newborns related to breastfeeding?
  o How can you resist unwanted or harmful advice?
  o What else can be done?
• Summarise discussion: Refer to picture this picture shows a couple turning down what is offered to them for their newborn. Sometimes refusal can offend those making offering, you can accept what is offered and not use it.
• Review the key messages with participants.

Key Messages:
• Mixed feeding or giving non-breast milk liquids, or foods other than prescribed medicine from a health facility can be harmful for all infants under 6 months.
• Mixed feeding in the first six months is particularly harmful if the mother is HIV-positive because it increases risk of HIV transmission to the baby.
• Do not give tea, herbs, gripe water, telament, foods or other liquids to your baby for the first 6 months. Resist pressure from others to give these things to the baby because any other liquids or food besides breast milk during the first 6 months can be harmful to the baby.
• If a baby has been prescribed medicine, the medicine can be combined with breast milk and given to the baby - do not combine the medicine with water or any other liquid. (The prescribed medication should only be taken within the prescribed period).
• Not all friendly advice is healthy advice.

SESSION 3.11 Reducing risk of HIV transmission during breastfeeding

Learning Objectives:
• Understanding elements of care necessary to prevent mother-to-child transmission of HIV during breastfeeding
• Understanding the importance of HIV testing for the infant and re-testing for the mother during the breastfeeding period

Time: 10 minutes

Facilitator Instructions:
• Review key messages and the picture with participants.

Key Messages:
• Be sure that your baby receives an HIV test:
  o At six weeks of age
Six weeks after you stop breastfeeding or when your baby is 18 months old

- If the baby becomes HIV-positive, follow the advice of health workers and ensure that your baby is getting the correct antiretroviral medication
- It is important to practice safe sex while you are breastfeeding as both the father and the mother can pass on infections, including HIV to their baby. One of the best and easiest methods is to use a condom.
- The baby should be given only breast milk for a period of 6 months, with exception of medications prescribed by a health care worker.
- You can join a family or mother support group at a local health facility where it is possible to get helpful advice about infant feeding as well as support for parents living with HIV.
- If the mother is HIV-positive:
  - Probing question: Refer to picture – what does this picture show?
  - The risk of transmission through breastfeeding is very small if the mother and baby are taking their medications and following the advice of the health care worker.
  - Breastfeeding allows the baby to get the important benefits of breastfeeding and breast milk.

**SESSION 3.12 Family planning**

Learning Objectives:

- Understanding the importance of selecting a family planning method before resuming sex postpartum
- Understanding the importance of dual protection

Time: 5 minutes

Facilitator Instructions:

- Probing question: Mothers can get pregnant 4 weeks after birth. How long would you like to wait before becoming pregnant again? Do you know how to delay becoming pregnant until you and your partner are ready?
- Remember: Family planning is a process, not just the use of contraception. It means having a child when you and your partner want to. It means avoiding unwanted pregnancy and pregnancy at the wrong time. It means you are able to control the size of your family.
- Review key messages and picture with participants.

Facilitator Note: Remind participants that the next session will start with a detailed look at the family planning methods but today is a quick introduction.

Key Messages:

- Before having sex after childbirth, even during breastfeeding, you should discuss your family planning goals with your partner and make a mutual decision around if and when you want another pregnancy.
- There are many family planning options available, and it is important to choose the best method to plan the timing of your next pregnancy, if you want another child.
Facilitator Note: Refer to picture – list all family planning methods but do not go into detail – detail is saved for next session.

- If you or your partner is HIV-positive, it is very important to consult a health care worker when planning your next pregnancy.
- Women have short-term and long-term reversible options; men and women both have permanent options. All of these options will be explained in more detail in the next session.
- Throughout breastfeeding, it is important to have a plan for dual protection (prevention of sexually transmitted infection as well as pregnancy), regardless of your HIV status. It is best to use condoms throughout the breastfeeding period.
- It is recommended that the mother waits for 6 weeks to heal before resuming sex. When you return to having sex, communicate with your partner, know what you want and decide on which family planning is best for you.
- Re-cap: What was covered today:
  - Reviewing your personal birth preparedness plan
  - What to expect during labor and delivery
  - Immediate care for the mother and the newborn after delivery
  - Danger signs in the mother and newborn after birth
  - Care for your newborn and yourself after birth
  - Importance of and tips for exclusive breastfeeding for the first six months
  - Myths and misperceptions about infant feeding
  - Reducing risk of HIV transmission from mother to baby
  - Family planning
  - The next session will be on: staying healthy after birth.

Facilitator Note: Let participants know when and where the next session will be.

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**Session 4 Staying Healthy After Birth**

4.1 Making a mutual decision about family planning
4.2 Reducing risk of HIV transmission from mother to baby
4.3 Nutrition during breastfeeding
4.4 Good communication to improve family health

*Overall session time: 1.5 hours*

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**SESSION 4.1**

**Making a mutual decision about family planning**

[Image of family planning methods]

*Learning Objectives:*

- Empowering women to start discussions about family planning with their partner
Time: 30 minutes
Facilitator Instructions:
• Re-cap last session and preview this session: In the last session we looked at: Preparing for Childbirth, Delivery and Immediate Postnatal Care. In this session we will look at staying healthy after birth:
  o Making a mutual decision about family planning
  o Reducing risk of HIV transmission from mother to baby
  o Getting good nutrition during breastfeeding
  o Good communication to improve family health

Discussion
• Lead discussion on common myths and misconceptions around family planning and sex.

Key Messages:
• There are several family planning methods available at your health facility: some are short-term, some are long-term and some are permanent. You should decide on your pregnancy goals and choose the best method for your needs.

Facilitator Note: Refer to picture that shows the family planning methods. The picture shows dual protection - using 2 types of protection, against STIs and for family planning. This is the safest and best approach to keep your baby safe.

<table>
<thead>
<tr>
<th>METHOD</th>
<th>DESCRIPTION</th>
<th>HOW IT WORKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pills – Combined oral contraceptives or “the pill”</td>
<td>Contains two hormones</td>
<td>Prevents the release of eggs from the ovaries (ovulation)</td>
</tr>
<tr>
<td>Progestogenonly pills or “the minipill”</td>
<td>Contains one hormone</td>
<td>Thickens cervical mucus to block sperm and egg from meeting and prevents ovulation</td>
</tr>
<tr>
<td>Implants</td>
<td>Small rods or capsules placed under the skin of the upper arm; contains one hormone only</td>
<td>Thickens cervical mucus to block sperm and egg from meeting and prevents ovulation</td>
</tr>
<tr>
<td>Monthly injectables or combined Injectable contraceptives</td>
<td>Injected monthly into the muscle, contains two hormones</td>
<td>Prevents the release of eggs from the ovaries (ovulation)</td>
</tr>
<tr>
<td>Coil (IUD)</td>
<td>A T-shaped plastic device inserted into the uterus that releases small amounts of the hormone</td>
<td>Suppresses the growth of the lining of the uterus</td>
</tr>
<tr>
<td>Male condoms</td>
<td>A sheath that fits over a man’s erect penis</td>
<td>Forms a barrier to prevent sperm and egg from meeting</td>
</tr>
<tr>
<td>Female condoms</td>
<td>A sheath, that fits loosely inside a woman’s vagina, made of thin, transparent, soft plastic film</td>
<td>Forms a barrier to prevent sperm and egg from meeting</td>
</tr>
<tr>
<td>Male sterilisation (vasectomy)</td>
<td>Permanent contraception to block or cut the tubes that carry sperm from the testicles</td>
<td>Keeps sperm out of ejaculated semen</td>
</tr>
<tr>
<td>Female sterilisation (tubal ligation)</td>
<td>Permanent contraception to block or cut the tubes that supply the egg</td>
<td>Eggs are blocked from meeting Sperm</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>Man withdraws his penis from his partner’s vagina, and ejaculates outside the vagina, keeping semen away from her</td>
<td>Tries to keep sperm out of the woman’s body, preventing fertilisation</td>
</tr>
<tr>
<td>Moonbeads</td>
<td>Calendar-based methods: monitoring fertile days in menstrual cycle; symptom-based methods: monitoring cervical mucus and body temperature</td>
<td>The couple prevents pregnancy by avoiding unprotected vaginal sex during most fertile days, usually by abstaining or by using condoms</td>
</tr>
</tbody>
</table>

Discussion
• Facilitate a discussion on dual protection. Suggested questions to get the conversation started:
  o What challenges do you anticipate with using dual protection with your partner?
  o What are successful approaches or ways to approach this discussion with your partner?
Wrap up discussion and review following key messages:

- Before resuming sex, it is important to discuss family planning with your partner because a woman’s body needs time to rest and heal in between childbirths and pregnancy.
- You should talk to your partner about when and if you want to have your next child and make a mutual decision together.
- It is important to have a conversation with your partner about when you would like to have another child before you start resuming sex; you don’t want to be discussing this in the heat of the moment!
- You can get more information about each available family planning option for you and your partner at the health facility. You should be prepared to discuss your options with your health care provider during pregnancy and during the 7 day visit to the health facility. Also be prepared to resume/start family planning 6 weeks after giving birth.

SESSION 4.2 Reducing risk of HIV transmission from mother to baby

Learning Objectives:

- Understanding elements of care necessary to prevent mother-to-child transmission of HIV
- Understanding the importance of HIV testing for the infant and re-testing for the mother during the breastfeeding period

Time: 10 minutes

Facilitator Instructions:

- Review the key messages with participants. Emphasize adherence to the prescribed medication for both mother and baby.

Key Messages:

- Mothers with HIV and their infants need extra care to reduce risk of HIV transmission. If you are HIV-positive, there are medicines that you and your baby need to take, including life-long antiretroviral therapy
- (ART) provided to HIV-positive pregnant and lactating mothers. Health facilities can provide medication and advice on prevention of mother-to-child transmission of HIV.
- HIV re-testing is important for both you and your partner throughout breastfeeding to reduce the risk of transmission of HIV to your baby.
- Be sure that your baby receives HIV tests:
  - At six weeks of age
  - Six weeks after you stop breastfeeding OR
  - When your baby is 18 months
- If your child becomes infected, it is important to seek and initiate treatment (ART) for the child as soon as possible.
- If you have HIV, you should breastfeed as long you and your baby are taking medications because the baby receives many important benefits from breastfeeding. The risk of transmission through breastfeeding is very small if the mother and baby are taking their medications and follow the advice of the health care worker.
- Once a person tests positive, they will always test positive because they will always have HIV, so there is no need to re-test. But it is important for those who are HIV-positive to receive a CD4 test and viral load and to follow all instructions received from the health care worker.
- It is important to use dual protection, including barrier methods (female or male condoms) throughout breastfeeding to prevent the spread of STIs, including HIV to the baby.

SESSION 4.3 Nutrition during breastfeeding

Learning Objectives:
- Understanding that the health of the mother is important for the health of the baby
- Understanding the importance of early and exclusive breastfeeding for the first six months of the baby’s life

Time: 15 minutes

Facilitator Instructions:
- Review the key messages with participants.

Key Messages:
- Staying fit and healthy after giving birth is one of the best things you can do for both you and the baby.
- New mothers need to eat well to keep up with the demands of a newborn. Your body has gone through a tremendous amount of change during pregnancy and childbirth that may have left you feeling exhausted.
- Breastfeeding requires even more additional food than pregnancy. Most breastfeeding women need nearly the equivalent of 1 to 2 extra meals per day to meet the energy needs of breastfeeding.
- Breastfeeding women also require more water.
- Women should also continue to take extra rest through the breastfeeding period, especially if a woman is unable to get the additional food, as this will help reduce energy expenditure.
• Eat a variety of foods, including animal products (where acceptable and possible), fruits, and vegetables. A nutritious diet is a balanced one; you need to eat a selection of food including vegetables and fruits, carbohydrates and proteins.
• Get enough water and liquids.

Discussion
• Facilitate a discussion on healthy foods and maintaining a balanced diet.
  o What foods are best to eat to stay healthy after birth?
  o Give examples of types of food that are: energy-giving, body-building and protective (regulating).

Facilitator Note: Use the picture during discussion.

• Response:
  o Energy-giving foods – wheat, rice, corn, fats, sweet potato, cassava, posho
  o Body building foods – soy, meat, chicken, fish, eggs, nuts, milk
  o Protective - vitamins and minerals are found in fruits and vegetables including pineapples, avocados, carrots, greens, mangoes, papaya and tomatoes
  o A mixture of these foods are required in your daily diet. And you need to drink more while breastfeeding.

Facilitator Note: Remember to always encourage exclusive breastfeeding for the first 6 months and remind women that all mothers can produce enough milk of good quality for their babies.
• Myth: There is a false belief that some women cannot produce enough milk for their babies. This is not true; in the vast majority of cases, women are capable of producing enough breast milk for a baby.

SESSION 4.4 Good communication to improve family health

Learning Objectives:
• Empowering women to discuss their pregnancy and the health of their family with their partners

Time: 30 minutes

Facilitator Instructions:
• Review the key messages with participants.

Key Messages:
• When both people feel comfortable expressing their needs, fears, and desires, trust and bonds are strengthened.
• A strong, healthy relationship can be one of the best supports in your life. Good relationships improve all aspects of your life, strengthening your health, your mind, and your connections with others.

Facilitator Instructions:
• Ask a volunteer to share experiences on communication strategies they use in their families.
• Probing question: If you want your husband to do something, what do you do? Communication strategies can include:
Here is a helpful way to start this difficult conversation when talking with your husband/partner – “I want to ensure that we have a healthy baby....”

Think about when you are going to talk to him. Try to find a time when you are both calm and there are no distractions.

Decide ahead of time if you need someone there for support – a friend or a family member.

Final Wrap-up of All Sessions

- Thank you for taking part in these sessions on maternal, newborn and child health. We have covered:
  - Staying healthy during pregnancy
  - Pregnancy and birth planning
  - Preparing for childbirth, delivery and immediate postnatal care
  - Staying healthy after birth

Discussion

Facilitate a discussion on what women have learnt from participating in these four sessions:

- Suggested questions to start the discussion:
  - Have these classes changed the way that you and your partner can have important discussions?
  - Have your views changed through participation in this group?
  - What challenges remain?
  - What support in your home or in the community do you have to address these challenges?

- Outline next steps that participants can take:
  - Put into practice what you have learnt in these sessions.
  - Encourage your peers to attend these MNCH sessions.
  - Form peer groups back in your community to provide continued support. (Extra support to groups outside of these sessions cannot be provided).
Peer Facilitator Guide to Maternal, Neonatal and Child Health for Men

1. Strong Informed, Powerful Men as Champions for Healthy Families
   1.1 Introduction, ground rules and programme overview
   1.2 Understanding men's roles in family and community
   1.3 Gender norms and health
   1.4 Prioritising health: actions men can take to keep themselves and their families healthy

2. Becoming a Father
   2.1 Building empathy for how women experience pregnancy
   2.2 Physical changes to a woman's body during pregnancy
   2.3 Understanding the importance of Antenatal Care
   2.4 Understanding what happens during Antenatal Care visits
   2.5 What you do affects the health of your baby
   2.6 Prevention of sexually transmitted diseases
   2.7 Modes of HIV transmission
   2.8 Communication in relationships

3. Are You Ready to Be a Father?
   3.1 Discussing HIV prevention and safer sex with your partner
   3.2 Danger signs during pregnancy
   3.3 Importance of a facility-based birth
   3.4 Planning for a facility-based birth
   3.5 Labor and delivery
   3.6 Bonding as a father with the baby

4. Keeping Your Family Healthy
   4.1 Importance of exclusive breastfeeding for the first six months of the baby's life
   4.2 Care for the mother following the delivery
   4.3 Danger signs in the mother after birth
   4.4 Danger signs in a baby
   4.5 Follow-up care for the mother and baby
   4.6 Keeping the baby HIV-free - reducing the risk of HIV transmission from mother to baby
   4.7 Family planning
   4.8 Taking responsibility as men for the health of the family
Session 1 Strong, Informed, Powerful Men as Champions for Healthy Families

1.1 Introduction, ground rules, and programme overview
1.2 Understanding men’s roles in family and community
1.3 Gender norms and health
1.4 Prioritising health: actions men can take to keep themselves and their families healthy

Overall session time: 2 hours

Materials needed:
- Flipchart paper(s)
- Markers
- Tape
- Stickers (ideally 3 different colors)
- Family Planning MOH IEC/BCC materials and condom demonstration kits (from health facility)

SESSION 1.1 Introduction, ground rules and programme overview

Learning Objectives:
- Frame expectations for the classes
- Recognise the value of participation in the full series of MCH classes

Time: 20 minutes

Facilitator Instructions:
- Introduce yourself and let participants introduce themselves. Encourage men to share with the group whether they are fathers, planning to become a father and how many children they have or intend to have, or whether they have a pregnant partner.
- Explain that these sessions will be held biweekly and ensure that this timing is agreeable to everyone and make adjustments to the schedule as necessary. The sessions will last 2-3 hours per session, for a total of 4 sessions. Emphasize that it is very important that participants attend all 4 sessions so that they can learn about ways men can protect their health and the health of their families.
- Set ground rules for the group. Some examples include:
  - Participate in all four sessions, share experience when you have it, respect others, it is okay to disagree.
  - If someone shares private information, such as their HIV status, it should not be shared outside of the group (need to emphasize this). Give examples of confidentiality. Allow the group to make some additional suggestions.

Key Messages:
Welcome! You have been invited to this programme to help you learn about protecting your health and the health of your family. This includes the health of your wife or partner before, during and after childbirth, and the health of your baby.

This programme is provided by The Elizabeth Glaser Pediatric AIDS Foundation or EGPAF, a non-profit organisation dedicated to preventing pediatric HIV infection and eliminating pediatric AIDS. EGPAF aims to increase community demand, uptake, and retention of Maternal and Child Health services to improve progress toward elimination of pediatric HIV.

The main reasons for these classes with different groups of men in the community is that:
  - Men are often the chief decision-makers when it comes to decisions about health of their families.
  - When men are positively involved in the health of their families, families have better outcomes.
  - Men can play a key role in helping their families access and adhere to health services.

There will be 4 sessions, each focused on different health topics important for men and the health of the family.

In today’s session we will be looking at:
  - Understanding men's roles in family and community
  - Gender norms and health
  - Prioritising health: actions men can take to keep themselves and their families healthy

SESSION 1.2 Understanding men's roles in family and community

Learning Objectives:
  - Explore various roles men play in their families and in their community
  - Help men understand how these various roles carry responsibilities

Materials:
  - Flipchart paper(s)
  - Markers
  - "I am" handouts
  - Tape/pins

Time: 40 minutes

Facilitator Instructions:

Group Exercise!
  - In advance of the session, prepare “I am ...” pieces of paper for each of the different roles that will be highlighted during the activity.
    - For example: I am the head of my family, I am a husband, I am a father, I am a son, I am a member of the community, I am a friend, I am a man.
    - Have a couple of spare pieces of paper for those who want to write their own.
  - Who are we as men? This next activity will look at our roles as men in the community.
  - Explain how the “I am...” activity works:
• Participants should stand-up and make a circle.
• The facilitator will read aloud a statement starting with the words, “I am ...”
• If participants fit into this category, they should go to the centre of the circle.
• Those that come to the centre of the circle will be given a slip of paper with the words ‘I AM...’ written on it and a piece of masking tape. Each person should then stick this slip of paper to themselves.
• Once everyone in the centre of the circle has attached the paper to themselves, they must run back to a new place in the circle. The last person to find a place in the circle must stay in the middle of the circle and read out loud a new “I AM...” statement.
• Again, those that fit into this category will come to the centre of the circle.

• Make sure everybody understands the instructions before beginning the activity.
• This game will last for about 10 minutes or until all of the different roles for men in the community have been read.
• Once the activity ends, ask participants to reflect on the game and count how many roles they play in their communities, etc.
• Ask if there is a volunteer willing to summarise all the men’s roles.
• Review the key messages with the picture for this session. Emphasize the main point of the exercise: to help men see that each of them plays various roles within the community, and that each of these roles carries responsibilities.

Key Messages:
• We can see that each of us play many roles. Sometimes we play many roles at the same time. Sometimes, we are only playing one role at a time. Each of these roles are important to who we are but they also place a large amount of expectation, and maybe even stress, upon us. For example, "As a provider, I am expected to give money to my family, pay for school fees, and food for the house."

Facilitator Note: Refer to picture showing the many different roles men play.

Facilitate discussion on Life Planning and Setting Goals and Making Priorities in Life.
• Link: We are identifying the different roles that we as men play. What goals and priorities do we have for these roles? Suggested questions to get discussion started:
  o Do you think it is important to have life goals?
  o What are some examples of life goals?
  o Is it important to set priorities and actions to meet those goals?
  o How can we balance responsibilities across all of the roles we play and still work towards life goals?
• Summarise life goals and the importance of accomplishing them.

Facilitator Note: It is important to remind participants of these goals and responsibilities as you progress through all of the sessions.

SESSION 1.3 Gender norms and health

Learning Objectives:
• Explore how expectations placed on men can affect their health as well as the health of their family
• Recognise gender norms and the way they impact health care seeking and ability to adopt healthful practices

**Time: 20 minutes**

**Facilitator Instructions:**

• Facilitate a discussion on ‘how gender norms affect health-seeking behaviour’. Suggested questions to get discussion started:
  
  - How are men supposed to act in their family?
  - How are men supposed to act in their community?
  - How do these expectations of men’s roles in the family and community affect our behaviours/the health of our families? For example, expectations and perceptions of testing for HIV together with your partner.
  - What are some of the problems/worries/barriers that we, as men, have in ensuring the health of our families, and in accessing healthcare?
  - How can we, as men, overcome some of the pressures/worries we face?

• Let the participants respond to these questions and share their thoughts. The discussion can last for about 10-15 minutes.

**Facilitator Note:** Try to focus the conversation on drawing out positive coping mechanisms for stress in men’s lives, such as exercise, remaining calm, only having difficult conversations with your partner when everyone is calm, etc.

• Wrap up the discussion by emphasising that trying to fulfil all of these expectations from our peers and community members affects our health and the health of the family.

• Review the key messages with participants.

**Key Messages:**

• Both men and women have shared roles as a family.
• A gender role is an accepted way of acting that is generally considered appropriate for either a man or a woman in the community. They are not biological but rather determined by society. These gender norms can lead to both positive and negative behaviour. For instance, it is the job of the woman to take care of the children and to cook. If a man were to do these things, it could be perceived that he was weak or that he has been bewitched by the woman. This makes it difficult for a couple to support and help each other in the interests of the family. These sessions will look at enabling men to protect the health of their families.
• Supporting your partners is important for the health of the family.
• Men have a responsibility for helping their families overcome barriers to good health.
• Sometimes the way men are expected to behave affects people in their lives as well as their own health. It is important for men to understand how these expectations and their decisions affect their partners and families.
• Probing question: What are examples of positive and negative gender roles and gender norms?
• How do gender norms affect health-seeking behaviour in men? For example, what makes men avoid acknowledging they are sick and in need of health care?
SESSION 1.4 Prioritising health: actions men can take to keep themselves and their families healthy

Learning Objectives:
- Help men understand that they should take the lead to promote the health of their families, including hygiene and Sanitation
- Discuss responsibilities of men as partners and fathers

Materials:
- Flipchart paper(s)
- Marker
- Tape

Time: 40 minutes

Facilitator Instructions:
Group Exercise: Hold Your Breath Exercise
- Before the exercise: Write the definition of health below on a flip chart paper, tape it on the wall, and cover it up: Health is not just being able to live without disease or sickness, it is the complete state of physical, mental and social well-being.
- Ask participants to respond to the following question: What are some of the things that you cannot live without in your lives?
- Give participants a few minutes to respond. If participants have not listed health as one of the key things they cannot live without, prompt them.
  - Explain to participants that you will count to 30, and that they should take a deep breath and hold it for as long as they can without exhaling or taking another breath.
  - Say ‘ready, set, go!’ Count to 30, (1, 2, 3... up to 30), and announce when you are finished after you have reached 30.
  - Ask the following questions after this exercise: Who was able to hold their breath for this long? How did you feel? Were you able to concentrate on anything other than your health? Now that you are able to breathe freely again, how does it feel?
- Review the key points from this exercise.
  - Uncover the definition of health from the flipchart and facilitate discussion on the key things men can do to stay healthy.
  - Review the following key messages with participants.

Key Messages:
- We did this exercise so you could literally feel how important your health is to your life. We breathe in and out every day to live. It’s something we do without paying much attention.
- The same thing applies to our health. We need to be healthy everyday to survive. It’s only when we stop being healthy or when we stop breathing that we notice how important that it is to us.
- When someone is unhealthy they may feel a lot of things you feel when you hold your breath. They may feel confused, tired, lonely, worried. They also may not be able to do anything physically or think about anything else except for their health. This shows how a disease can affect a person physically and mentally as well.
Defining Health

- Suggested questions to get discussion started:
  - What are some things you do to stay healthy?
  - What are things that you do that are risks to your health?
  - What are resources in the community to keep you healthy?
  - What is your role in looking after the health of your family?

Sum-up discussion: Refer to the picture showing a responsible man looking after his health and the health of his family. Emphasize the positive behaviour and tips mentioned.

**Facilitator Instructions:**
Wrap up the session with the following key messages:

- Health practices that men can do to stay healthy include regular exercise, avoiding risky behaviours (excessive alcohol, having multiple sexual partners), regular screening for diseases like high blood pressure, diabetes, and STIs including HIV.
- Sum-up discussion: Refer to the picture showing a responsible man looking after his health and the health of his family. Emphasize the positive behaviour and tips mentioned.

**Facilitator Instructions:**
Wrap up the session with the following key messages:

- Health practices that men can do to stay healthy include regular exercise, avoiding risky behaviours (excessive alcohol, having multiple sexual partners), regular screening for diseases like high blood pressure, diabetes, and STIs including HIV. Men should take the lead to promote the health of their families including hygiene and sanitation.
- Poor hygiene and sanitation in the household can cause many diseases.
- Alcohol drinking and smoking affects the health of men and their families.
- Today, this session covered:
  - Introduction, ground rules and programme overview
  - Understanding men's roles in family and community
  - Gender norms and health
  - Prioritising health
- During the next session, we shall be talking about the role men can play in supporting their wives during pregnancy.

*Facilitator Note: Let participants know when and where the next session will be.*

**Session 2 Becoming a Father**

2.1 Building empathy for how women experience pregnancy
2.2 Physical changes to a woman's body during pregnancy
2.3 Understanding the importance of Antenatal Care
2.4 Understanding what happens during Antenatal Care visits
2.5 What you do affects the health of your baby
2.6 Prevention of sexually transmitted diseases
2.7 Modes of HIV transmission
2.8 Communication in relationships

**Overall session time: 2-3 hours**

**Materials needed:**
- MOH IEC/BCC materials on Preventing Mother-to-Child Transmission of HIV
SESSION 2.1 Building empathy for how women experience pregnancy

Learning Objectives:

• Help men understand how they have a role to play in supporting the health of their unborn children and partner

Time: 25 minutes

Facilitator Instructions:

Recap: In the previous session we looked at: Strong Informed Powerful Men as Champions for Families. In this session we will look at:

• Building empathy for how women experience pregnancy
• Physical changes to a woman’s body during pregnancy
• Understanding the importance of Antenatal Care
• Understanding what happens during Antenatal Care visits
• What you do affects the health of your baby
• Prevention of sexually transmitted diseases
• Modes of HIV transmission
• Communication in relationships

Facilitator Note: Explain that becoming a father begins at conception, so we will be discussing pregnancy. This is not something that most men discuss, is it? It is important to understand that a healthy family begins by keeping mother, baby and father healthy.

Discussion

Discussion on the “pregnant” man picture.

Suggested questions to get discussion started:

• How do you feel about this picture and why?
• Is this a common sight?
• Do men walk around like this in your community carrying food on their heads and babies on their backs?
• Of course we know that men cannot get pregnant, but how does it make you feel to think about what your partner experiences during pregnancy?
• Are there any ways men can support a woman during the time of pregnancy?

Facilitator Note: This picture is supposed to be provocative to spark reactions and dialogue among men, but the facilitator needs to strike the right tone of fun and seriousness. Clarify to the participants that men cannot actually get pregnant, but rather this picture is designed to help men empathise with how a woman experiences pregnancy and all the roles that a woman also has.

• Review the following key messages with participants.

Key Messages:

• This session is focused on what you can do to support the health of your unborn child.
• Even when your wife or partner is pregnant, your behaviour affects the health of your wife and your unborn child.
• To have the best outcome for unborn babies, men should be supportive of their partners before, during and after childbirth and seek maternal care and advice together.
• Supporting your wife or partner with birth planning contributes to the best outcome for the unborn baby.

**SESSION 2.2 Physical changes to a woman’s body during pregnancy**

**Learning Objectives:**
• Help men explore what they know about pregnancy and the changes that happen to a woman’s body during pregnancy
• To convey to men what they can do to support their partners at each stage of pregnancy

**Time: 10 minutes**

**Facilitator Instructions:**
• Review the key messages and picture with the participants.

**Key Messages:**
• During pregnancy, the baby is growing inside the woman’s womb.

**Facilitator Note:** Refer to picture showing different stages of pregnancy.
• During pregnancy, a woman’s body experiences physical and mental changes and many women experience social pressures during pregnancy as well.
• There are discomforts that may make a woman feel sad, angry, stressed, or unwell. This includes, morning sickness/nausea, heartburn, constipation, hemorrhoids, changes to the birth canal, discharge and varicose veins. Unless prolonged or intense, most of these discomforts can be made better by resting, eating well – vegetables and fruit, and light exercise – you can support your partner/wife with this.

**Facilitator Note:** Detailed information on discomforts can be found in the reference section at the back of this manual.
• A woman’s body produces hormones during pregnancy that help the baby grow, and these hormones can cause emotional changes in her as well, including mood swings.
• She may want to have sex, but she may not. It is important to understand and discuss with her what she wants and how she feels.
• Your partner needs extra nutrition during pregnancy because she is eating for two. She needs rest and should avoid lifting heavy objects and doing hard physical work. Men can support their women to make sure they get the nutrition and rest they need throughout their pregnancy to ensure a healthy baby.
• Younger wives need extra support because sometimes their bodies are not ready and fully developed to handle all of the physical, mental and emotional changes that happen during pregnancy.
• Question: What do you do if your partner is not interested in engaging in sex?

**Discussion**
• Facilitate discussion among participants for 2 – 3 minutes.
• Sum-up: There are strategies and ways to help men understand and support their partners during pregnancy. It is also good to avoid harmful practices such as taking multiple partners when the woman is pregnant or breastfeeding, as this increases the chances of contracting
SESSION 2.3 Understanding the importance of Antenatal Care (ANC)

Learning Objectives:
- Understand the importance of men’s support for complete use of ANC services and birth preparedness

Time: 5 minutes

Facilitator Instructions:
- Review the key messages with the participants.

Facilitator Note: The services given in ANC will be provided in the next session; this session is about the importance of attendance.

Key Messages:
- It is important for women to go to the health facility during their pregnancy to receive the care, support and medicines they need to ensure they are healthy and their bodies can support the healthy growth and development of the baby during the pregnancy. You can accompany your pregnant wife or partner to the health facility to receive ANC.
- It is recommended that pregnant women complete at least 4 ANC visits, or more as recommended by the health care worker. A woman should go as soon as she suspects she is pregnant, after her 1st or 2nd missed period, even before she starts showing. She should go to the health facility where she will be assessed and cared for during her pregnancy.
- 1st ANC visit is recommended in the 1st trimester (between 1 and 3 months).
- 2nd ANC visit is recommended in the 2nd trimester (between 3 and 6 months).
- 3rd and 4th ANC visit is recommended in the 3rd trimester (between 6 and 9 months).
- Some women may need more than 4 visits, and they should be supported to follow the visit schedule recommended by the health care workers.
- You should accompany your partner to the health facility during at least one of her Antenatal Care visits as there are services men can receive to ensure the health of the family and to understand what is happening with the pregnancy.
- Health care services available to you at the health facilities include blood pressure check-up, blood sugar check-up, HIV testing, prostate cancer screening and general check-up.
- Men should support their partners in following the advice of the healthcare workers throughout pregnancy, and ensure that women take the medicines and vitamins received from the healthcare worker.
SESSION 2.4 Understanding what happens during antenatal care visits

Learning Objectives:

- Increase male support to pregnant women for early and complete use of ANC and birth preparedness

Time: 5 minutes

Facilitator Instructions:

Facilitate a discussion on what Antenatal Care (ANC) provides.

- What do you think happens in Antenatal Care?
- Review the key messages and picture with the participants:

Key Messages:

Antenatal care includes a range of services that are provided to ensure the health of the mother and baby.

General ANC visit:

Examination and screening

Facilitator Note: Refer to 2nd ANC picture.

- Blood pressure will be taken to make sure there are no pregnancy complications.
- Weight and height will also be measured. A physical examination will be done to make sure the baby is growing normally and that the expectant mother is ready for a safe delivery, and to listen to the baby’s heartbeat.

Facilitator Note: Refer to 2nd ANC picture.

- The expectant mother will be screened for conditions and infections that can affect her pregnancy and unborn baby, including malaria, diabetes, high blood pressure and anaemia. Screening involves blood and urine tests.
- The expectant mother and her partner may also be tested for possible STIs such as HIV and syphilis. It is best if your partner comes with you and that you are tested for HIV and syphilis together.

Facilitator Note: Refer to 1st ANC picture.

- If the expectant mother tests positive for syphilis, she and her partner will be required to take treatment (usually an injection).
- If the expectant mother is HIV-positive, she will be given counselling and medicine to reduce the risk of transmitting to the baby, and for taking care of her own health.
- It is important that you attend one of the Antenatal Care visits for screening, as there is a risk of infection passing from you to your partner and your baby during pregnancy and breastfeeding.

Immunizations

Facilitator Note: Refer to 1st ANC picture.

- The expectant mother will be given immunizations, including a tetanus shot, to protect her and the baby.

Health Education and Counselling

Facilitator Note: Refer to 1st ANC picture.

- Health education and counselling; nurses will ask questions about the expectant mother’s health, including possible sexually transmitted infections, as well as any complications she may have
experienced from any previous pregnancies or childbirths. It is important to raise any existing health problems of both the expectant mother and expectant father, such as diabetes, TB, high blood pressure, HIV, and anaemia with the health care provider.

**Facilitator Note:** Refer to 2nd ANC picture.

Supplements will be provided including iron/folic acid

- Probing question: Why does ANC test for sexually transmitted infections? What are the effects of STIs on unborn babies (fetus)?
- Response: It is possible to test for and treat certain STIs. Syphilis, chlamydia and gonorrhoea can all be passed on to, and seriously harm the unborn baby, but they can be tested for, treated and cured during pregnancy. HIV/AIDS, genital herpes, hepatitis B, hepatitis C and HPV (human papillomavirus – a cause of cervical cancer) are caused by viruses but in some cases, including HIV, they can be treated with medications to reduce the risk of passing the infection to the baby.
- Going to ANC provides testing and treatment for these STIs and protection for the unborn baby. You are encouraged to accompany your wife or partner to at least one of these visits, and be tested for HIV.
- If you acquire any of these infections and pass them to your wife while she is pregnant, there could be very serious harm done to the mother and the baby. That is one reason why a woman who has tested HIV-negative early in her pregnancy will be retested later.

**Facilitator Instructions:**

- Recap key messages: ANC provides the following services:
  - Health promotion: educating women to eat nutritious foods during pregnancy and have enough rest
  - Preventing and treating infections
  - Baby growth and positioning: baby growing well and positioned well?
  - Testing and treating STIs: including testing and re-testing for HIV, for both the mother and her husband or partner.
  - Prevention of mother-to-child transmission (PMTCT) of HIV: if a woman is found to be HIV-positive, she can prevent passing the HIV virus to her baby by taking antiretroviral drugs or ARVs.

**SESSION 2.5 What you do affects the health of your baby**

**Learning Objectives:**

- Understanding that men have an important role to play in helping protect the health of their partner and unborn baby

**Time:** 20 minutes

**Facilitator Instructions:**

*Facilitator Note:* This sub-section represents a bit of a transition into a new topic area from the previous session focused on ANC services; facilitators should make this transition clear. We have just talked about the important services a woman needs to receive during ANC, but YOUR health is also important for your baby’s health and the health of the family. Link to the life goals set in the first session – your health as a husband, father, man, etc.
• Review the key messages with participants.

Key Messages:
• Throughout pregnancy and the breastfeeding period, your health is also important for your baby’s health.
• What you do affects the health of your partner, your baby and your family.
• During your partner’s pregnancy you should minimize stress and avoid violence – what hurts your partner, also hurts your unborn child, and the family.
• It is best to avoid smoking and excessive drinking.
• Common stressors in men’s lives and positive ways to cope with stress.
  o Suggested questions to get discussion started:
    o Look at this picture. What do you see?
    o What are common frustrations and stressors in men’s lives?
    o How do these stressors escalate into violence?
    o Why does violence happen in the household?
    o What are positive ways to cope with stress and avoid hurting your partner and your baby?
• The discussion should last about 15 minutes, after several participants have had a chance to share their thoughts.
• Try to summarise positive coping mechanisms that may have been shared by participants such as:
  o Taking a break from a heated discussion to cool off
  o Exercising to clear your head
  o Seeking the help of a family member or a friend to resolve a disagreement with your partner, etc.

Facilitator Note: In the field test, women were quick to blame men, and men were also quick to blame women. The tone and emphasis on this discussion should be placed on self efficacy and personal responsibility for ensuring positive health outcomes.

Facilitator Note: Review the following key messages:
• Men can be supportive to their partner during pregnancy by being nice, patient and understanding, but men should also take responsibility for their own health to ensure the health of their baby and their partner.
• During pregnancy, men should receive screening at a health care facility for HIV, syphilis and other STIs, as these infections can be passed on to the mother and the baby. It is best to agree to go with your partner to get tested together so that you can get treatment if needed and discuss the results with your partner and make a plan to protect the baby.
• Men have a responsibility to take care of their own health to prevent and treat infections of any kind that can be passed to the mother and the baby. Men should follow the advice of the health care worker, including adherence to any medicines prescribed by the health care worker, and also support their partner to take medicines as prescribed by the health care worker.
SESSION 2.6 Prevention of sexually transmitted diseases

Learning Objectives:
• Understanding the importance of consistent condom use for prevention of STIs
• Understanding the importance of regular screening for STIs

Time: 10 minutes

Facilitator Instructions:
Fears and issues around going to a clinic for testing.

Discussion
• Possible questions:
  o What is an STI? What are some STIs that you know? And what are the signs and symptoms?
  o Is HIV an STI?
  o What STIs can be cured?
  o Why might some be reluctant to go to the clinic to be screened for STIs?

• Ensure discussion includes the following messages:
  o Definition: Sexually transmitted diseases (STDs), or sexually transmitted infections (STIs), are generally acquired by sexual contact. The organisms that cause STDs may pass from person to person in blood, semen, or vaginal and other bodily fluids.
  o List the examples of STIs.
    o Some infections can be transmitted non-sexually, such as from mother to infant during breastfeeding; these include HIV, hepatitis A, hepatitis B and herpes.
    o Generally, the symptoms of STIs (other than HIV) can include:
      o Unusual discharge from the penis, vagina or anus
      o Pain during sex or urination
      o Sores, blisters, ulcers, warts or rashes in the genital area
      o Itchiness or irritation in the genital area
      o Persistent diarrhea
      o Fever or flu-like symptoms
      o Abnormal or unusual vaginal bleeding, especially after having sex
      o Pain in the scrotum or testicles
      o Lumps and bumps on the genitals
  o It is possible to test for and treat certain STIs, including HIV/AIDS. This reduces the risk of transmitting the infection to the breastfeeding baby. HIV cannot be cured, but treatment with anti-viral medications can keep the mother healthy and significantly reduce the risk of passing the infection to the baby or to the partner. If a man has HIV, he should be sure that he gets the appropriate care and treatment services to keep himself healthy and reduce the risk of passing HIV to the partner.
  o Wrap up discussion with the picture and highlight the importance of communicating with your partner and getting tested, especially the benefits of going with your partner. Benefits include mutual support and joint disclosure.
• Review key messages with participants.
Key Messages:

• If you have sex without a condom, you are putting yourself at risk for catching a sexually transmitted disease or infection. It is best to always use a condom and know your status.

• Open sores in the genital area are always serious and need treatment immediately for the safety of the man, the partner and the baby.

• Symptoms of sexually transmitted infections are not always obvious. In fact you could have a sexually transmitted infection like HIV and have no signs or symptoms, but you are still at risk of passing it to others. This is why it is important for you and your partner to go for STI testing.

• HIV infection usually has no outward symptoms until the disease is well-advanced, so it is important to screen ALL pregnant women and their partners, even if they feel that they are not at risk. By the fact of being pregnant, there has been sexual activity so all pregnant women are at risk.

• You should be screened on a regular basis to identify potential infections and get treated before passing them to others. If you think you have a sign of a sexually transmitted infection or have been exposed to one, it is best to get yourself tested at a health care facility.

• HPV (human papillomavirus) is sexually transmitted and carried by men. It can cause cervical cancer in women and cause complications during birth for mother and baby. Encourage your partner or wife to go for cervical screening, if available near you.

• Some sexually transmitted infections can be treated easily or eliminated, but others require long-term treatment.

• It is essential you and your partner be tested and treated, especially since when left untreated, sexually transmitted infections can increase your risk of acquiring another sexually transmitted infection, including HIV.

SESSION 2.7 Modes of HIV transmission

Learning Objectives:

• Understanding most common modes of HIV transmission and how consistent protection is always necessary

• Ensure understanding of the connections between HIV infection in the man, and health outcomes for mothers and children

• Understanding what parent-to-child HIV transmission is and how it can be prevented

Materials:

• MOH IEC/BCC materials on Preventing Mother-to-Child Transmission of HIV (PMTCT) – found at health facilities

Time: 25 minutes

Facilitator Instructions:

• Probing question: How is HIV transmitted? Answers are provided in the key messages.

• Review the key messages and picture with participants.

Key Messages:

Facilitator Note: Refer to the picture for the following key messages:

HIV can be transmitted:
• Through having unprotected sex with an HIV-positive partner
• Through transmission of the virus from an HIV-positive mother to her baby during pregnancy, delivery or breastfeeding
• Through sharing of needles with an HIV-positive person, which is a common practice in some parts of the world
• Through exposure to HIV-positive blood products
• HIV cannot be transmitted through casual contact. You cannot get HIV by any of the following activities:
  o Patting someone on the back
  o Sharing equipment or tools
  o Sharing toilets
  o Shaking hands
  o Hugging
  o Coughing
  o Sneezing
  o Drinking from the same water source
  o Using the same telephone
  o Eating together or sharing utensils

Activity: The Sticker Exercise
  1. Have stickers of three different colors.
  2. Each participant is assigned a color and given a set of stickers with those colors.
  3. Each person should put their assigned colored sticker on their shirt front.
  4. There should be at least 2 people assigned “red” and 2 assigned “blue”, with all the rest being assigned a third color. The actual colors don’t matter, but there needs to be 3 different colors with the majority being all the same color and a minority being the other 2 colors.
  5. Tell each person to go and shake hands with 4 other people. When they shake hands, they should give the other person an additional sticker from their set so that each now has another sticker on their shirt front.
  6. At the end, everyone should have multiple stickers on their shirts, some may have all the same color and some with mixed colors.
  7. Tell the group that the ones with “red” stickers (or the color that you assign to be the one with HIV) now have HIV. The ones with “blue” stickers (or the color assigned to be the one representing a pregnancy) now have a pregnant partner. Anyone with a red and blue sticker may have passed HIV to their pregnant partner and maybe to their unborn child. The 3rd color is the neutral group, or the ‘protected group.
  8. Discuss how each of them feel about their colors, ensuring that everyone gets a chance to talk about the mix of their stickers and how they feel now with them.

Facilitator Instructions:
Review the following key messages with participants:
• A person can have HIV without showing any signs or symptoms and may not even be aware that they are infected.
• Having outside partners when your partner is pregnant or breastfeeding can bring new HIV infections to the partner and baby.
• It is important to keep HIV out of pregnancy – the infection can come from either the mother or the father.
• It is possible for one person in the couple to be HIV-positive and the other to be HIV-negative. This is called discordancy. In a couple that is discordant, special attention must be paid to keeping the HIV-negative partner free of HIV.
• Parent-to-child transmission of infections, including HIV, can be prevented.
• Getting tested for HIV is the first step to protecting your own health and can help prevent infections to partner and child; re-testing throughout pregnancy and breastfeeding is important.
• Agree to get tested together; it is important for each partner to know their status to ensure the health of the baby.

Treatment
• If there is HIV in the pregnancy, it is important to treat the HIV. If the woman is infected, preventing mother-to-child transmission of HIV (PMTCT) can be done if she takes the medicines she is prescribed to prevent transmission to the infant. This includes providing life-long antiretroviral therapy (ART) to HIV-positive pregnant and lactating mothers.
• If the man is infected, he should take any medicines prescribed and use a condom to protect his partner.
• All sex during pregnancy and throughout breastfeeding should be protected to ensure the best outcome for the baby.
• Sex outside the couple can be extremely dangerous to the baby as it may introduce HIV into the pregnancy.

Facilitator Note: Include any MOH IEC/BCC materials to pass out to participants for additional information.

SESSION 2.8 Communication in relationships

Learning Objectives:
• Begin to address challenges related to communication around safer sex, and prevention of HIV, STIs and unintended pregnancy

Time: 30 minutes

Facilitator Instructions:
Ask participants to imagine what they would do in each of the following situations and share potential ideas on how to manage such difficult conversations with a partner:
1. Your partner asks you to use a condom, how do you react?
2. Your partner invites you to come with her to the health facility to get an HIV test together, how do you react?
3. Suppose your partner finds out that she is positive at ANC—would you want her to tell you?
4. What if you find out that you are HIV-positive when you get tested, how would you tell your partner? What would you do?
5. How would you want your partner to begin a conversation about protecting your baby and getting tested/practising safe sex?

Review the key messages and picture with participants.

Key Messages:
• It is very difficult to talk about some of the issues surrounding HIV and STIs with your partner.
• But with HIV, if one partner is positive, the other partner and child can remain negative. Finding out about discordance is just as important as finding your own status. Mutual disclosure is the first step toward healthy resolution. Testing together is easier than testing separately for mutual disclosure.
Facilitator Note: Refer to picture – discussing issues such as STIs, can be difficult. Talking about it at a health facility where health professionals can give useful advice is often the easiest way to discuss these issues with your partner.

- Here is a helpful way to start this difficult conversation when talking with your wife/partner – “I want to ensure that we have a healthy baby...” or “I want to ensure that we are both healthy...”
- Think about when you are going to talk to her; try to find a time when you are both calm and there are no distractions.
- Decide ahead of time if you need someone there for support – a friend or a family member.
- Your partner or wife may try to start a conversation like this, especially if she is attending these sessions. This is an opportunity to talk about these issues and ensure the health of your family.
- Develop a plan to both get tested following the conversation and share the test results with each other.

Today, this session covered: Becoming a Father and included topics like:

- Building empathy for how women experience pregnancy
- Physical and emotional changes to a woman’s body during pregnancy
- Understanding the importance of Antenatal Care
- Understanding what happens during Antenatal Care visits
- What you do affects the health of your baby
- Prevention of HIV and other sexually transmitted diseases
- Modes of HIV transmission
- Keeping HIV out of the pregnancy
- Communication in relationships

In the next session we will review the role men can play in the birth of their baby, and bonding with their baby.

Facilitator Note: Let participants know when and where the next session will be.

Homework assignment before the next session:
Talk to your partner about HIV. Use phrases like, “I want to ensure that we have a healthy baby...” or “I want to ensure that we are both healthy...”

Session 3 Are You Ready to Be a Father?

3.1 Discussing HIV prevention and safer sex with your partner
3.2 Danger signs during pregnancy
3.3 Importance of a facility-based birth
3.4 Planning for a facility-based birth
3.5 Labor and delivery
3.6 Bonding as a father with the baby

Overall session time: 2 hours

Materials needed:

- Copy of a Birth Preparedness Plan
SESSION 3.1 Discussing HIV prevention and safer sex with your partner

Learning Objectives:

• Share experiences related to content of the previous session, particularly successes and challenges in communication with spouse or partner on prevention of HIV and safer sex practices
• To have men understand HIV prevention and safe sex practices
• Understand danger signs and the importance of facility based birth

Time: 15 minutes

Facilitator Instructions:

In the last session we looked at ways in which men can support the health of the pregnant wife and unborn child. In this session we will look at:

• Discussing HIV prevention and safer sex with your partner
• Danger signs during pregnancy
• Importance of a facility-based birth
• Planning for a facility-based birth
• Labor and delivery
• Bonding as a father with the baby

Key Messages:

Recap from Session 2 – In the last session we discussed communication in relationships, including how to talk about STIs, including HIV, with your partner.

Suggested questions to get discussion started:

1. Since our last session were you able to discuss STIs, including HIV, with your partner?
2. How did your partner react? Was this challenging?
3. What advice do men have to share with each other about how to talk to your partner about using a condom?
4. What challenges did you face bringing up HIV with your partner?

Discussion

• Summarise the discussion on communication techniques.
• Link: Protecting your partner and unborn baby from HIV infection is one way to be a responsible father. Another is to be aware of the health and well-being of your partner or wife as she progresses through pregnancy and to fulfil your life goals that we discussed in the first session.

SESSION 3.2 Danger signs during pregnancy
Learning Objectives:
- To have participants identify danger signs during pregnancy
- To help men understand risks and potential complications involved in pregnancy and what to do – especially in an emergency situation

Time: 20 minutes

Facilitator Instructions:
Facilitator Note: Facilitators should transition from how to communicate with partners to how men can be supportive and assume responsibility for ensuring a safe pregnancy and delivery for their partner and baby.

- Review key messages with participants.

Key Messages:
- During pregnancy women sometimes face complications that can put both their life and the baby’s life at risk; these complications often have danger signs.
- Most causes of death for the mother and the baby can be easily prevented if the danger signs are recognized early and prompt medical attention is received.
- Planning ahead is essential to ensure safe outcomes and this session will help you think about your role in ensuring safe outcomes for the mother and the baby.

Discussion
Experiences with maternal death during pregnancy and delivery
Suggested questions to start the discussion:
1. Do you know any women that have died during pregnancy or childbirth in your communities?
2. What did people say about why they died?
3. What do you think could have been done to prevent these deaths?

Facilitator Note: The purpose of this discussion is to ensure that common myths and misperceptions are dispelled regarding bewitching and maternal deaths. Facilitators should emphasize that there are medical explanations for complications that could have been prevented if they were recognised and treated on time.

Facilitator Instructions:
Review the following key messages and picture with participants:
- While there are many common discomforts that women experience during pregnancy, these can usually be managed. But there are certain signs that indicate danger and require immediate medical attention:

Facilitator Note: Refer to picture showing the following danger signs.
1. Very weak and tired, short of breath (can be a sign of severe anemia)
2. Swelling in hands and face is always a danger sign (mild swelling of the feet can be commonly experienced during normal pregnancy)
3. Headache with blurry vision or fits
4. Severe pain in belly
5. Bleeding from vagina, fluid with bad smell - green or brown
6. Contractions or rupture of membranes (water breaking) before 37 weeks
7. Fever (infection)

- While many communities have beliefs about why women die during pregnancy and childbirth, the reality is that there are often medical explanations for complications that could have been prevented if they were recognised and treated on time.
- If you see any of these danger signs in your partner, you need to assist her in getting help right away – go to a health care facility immediately because your partner and her baby are at risk of losing their lives.
- Do not try to manage these conditions at home, as the help of a professional healthcare provider is needed to support the woman and her baby.
• These conditions are not about bewitching and cannot be handled by a traditional healer. You need to know where the closest health facility is and how you will get there – it is important to plan ahead and not wait for an emergency.

Facilitator Note: Peer facilitators should try and find out the location of the nearest health facilities, which provide maternity services, and encourage participants to identify their nearest health facility.

SESSION 3.3 Importance of a facility-based birth

Learning Objectives:
• To have participants understand the importance of a facility-based birth

Time: 20 minutes

Facilitator Instructions:
• Review the key messages with participants.

Key Messages:
• Every woman, regardless of her HIV status, should plan to deliver at a health care facility, where she and her baby will have access to life-saving services in case of any complications during the delivery.
• Men have an important role to play in helping their partners create a plan for a facility-based delivery at a health care facility.
• All pregnant women are given an expected date of delivery, but this date may be inaccurate or the baby could come much earlier or later, so it is important to be ready well in advance.
• It is important for partners to discuss their plan for arriving to the health care facility in time to ensure a safe delivery of the child. Make sure you identify facilities that provide maternity services and support for giving birth. Every woman should have a facility-based birth to protect both the baby and the mother, and precautions should be taken with contact with blood and body fluids.
• Infection during the delivery is a serious and common cause of death for both mother and baby.
• During labor and delivery, life-threatening emergencies for both the mother and the baby can arise quickly that require the help of skilled birth attendants, so it is best to have a plan to deliver in a facility. Whether a pregnant woman has HIV or not, complications such as retained placenta or a breech birth (where the baby comes out feet first) can be life-threatening and are best handled in a health facility.

Facilitator Note: Refer to the picture that shows some of the benefits of a facility-based birth including health attendants and sterile/clean equipment.

Discussion
Barriers women face to reaching the health facility in time for a safe delivery.
Suggested questions to start the discussion:
• What are some barriers women face in having a facility-based birth?
• How can planning help overcome these barriers? Consider: knowing where there is a maternity hut nearby the health facility where a woman can stay when she is in labor.

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Facilitator Note: Discussions may turn to the poor quality of care at a facility and that women don’t go there. If this comes up, the facilitator should be prepared to follow up and suggest that they bring their concerns to one of the community leaders to see what can be done. In the meantime, the family needs additional support to arrange for a safe delivery.

- Summarize discussion by emphasizing the importance of planning to ensure a safe delivery.

SESSION 3.4 Planning for a facility-based birth

Learning Objectives:
- Provide tools for participants to plan for a facility-based delivery
- To have participants understand and support birth planning, taking responsibility for needs such as planning for costs and transport
- Discuss birth planning with partner, other household members, and community members (such as emergency transport drivers, etc.) engaged in safe motherhood activities

Materials:
- Copy of a Birth Preparedness Plan

Time: 20 minutes

Facilitator Instructions:
- Facilitators should review all of the elements of the birth preparedness plan, and set out as the key messages in this session with participants to make sure they understand why this is important and to help give participants talking points so they can plan with their partner for a facility-based birth.

Facilitator Note: This is the same template women will have been given and reviewed in the parallel MCH classes to bring home and initiate a discussion with their partners on addressing the things they need to prepare or plan for a facility-based birth.

- Facilitators may want to ask if any of the men have a partner that has already shared this planning tool with them – and to share their experiences on having such a discussion with their partner. Did they face any challenges?

Key Messages:
A full birth preparedness plan requires the following elements:
- Identifying where your partner or wife intends to deliver.
- How will she get to maternity services? If needed, what emergency transport options are available in your community?
- How much money do you need to save to cover costs, including transport, health centre fees and food?
- Will she need to use maternity huts/homes nearby the health facility? Or do you have a family member nearby where she can stay?
- Who will provide childcare for other children in the family during the delivery?
• Who will support your partner/wife during labor and delivery?
• If your partner experiences any of the danger signs during pregnancy or if the birth comes early, how will she get to the health facility? Do you need to help? What happens if you and/or your partner are away from home at the time of labor and delivery?
• If your community has an emergency transport system, let them know your partner is pregnant and make sure you have a contact number to reach them in case of an emergency.
• What is required by your partner and baby (hat, blanket, nappies, etc.)?
  o For the baby: baby blanket, baby receiver, towels, nappies, baby clothes
  o For the mother: sanitary pads, toiletries, clothes, blanket

Facilitator Note: Refer to the picture that shows the key items that need to be prepared and brought along for a facility-based birth.
Facilitator Note: Where possible, check with the health facility beforehand to see what items will be provided and what items the family should bring with them.

SESSION 3.5 Labor and delivery

Learning Objectives:
• Helping men understand what to expect during labor and delivery
• How partners can be supportive during labor and delivery

Time: 10 minutes
Facilitator Instructions:

Questions:
• How many children do you have and how involved were you in their delivery?
• What were/are the biggest threats to the health of your partner or wife, and unborn baby?

Discussion
Facilitator Note: If infection is not raised, prompt and lead a discussion on ways to prevent infection:
• Make sure everyone who comes into contact with your partner or wife and baby has washed their hands.
• Be sure that all equipment used in childbirth is clean.

Facilitator Note: Refer to this image showing a mother giving birth in a health facility. In the facility, the health staff can monitor her, help ensure a safe birth and place the baby on her chest after birth so that the newborn can immediately start to breastfeed.
• Review the key messages with participants.

Facilitator Note: Peer facilitators needs to stress the importance of a facility-based birth.

Key Messages:
• Labor begins when contraction pains are regular (same amount of time between each one) OR the water breaks. Other signs of labor include a gush of clear water from the vagina; clear or pink mucus from the vagina; and contraction pains.
• Once labor begins, help your partner get to the health care facility as soon as possible. For those women who live far away from the health facility, it is recommended that she go to the maternity waiting rooms or a family/friend’s home near the health facility when she is at the end
of her pregnancy (9 months pregnant). Her expected date of delivery will be given when she (and you) go to Antenatal Care (ANC).

- Try to help your partner feel as comfortable as possible during labor; remind and encourage her:
  - To eat small meals and drink when thirsty.
  - To walk around for comfort; this can also help labor to progress faster.
  - Help her to go to the bathroom regularly (once an hour is normal).
  - Help her stay calm by reminding her to take regular, deep breaths.
  - Help her change positions to encourage the progress of labor.
  - Your involvement and other personal labor support during delivery can be helpful to your partner, but check on what is possible at your health facility.

- After the baby comes – the baby will need to be warmed and dried with a clean cloth, and placed on the breast for feeding. After the baby comes, the placenta will come. The cord will be cut and tied by the health care worker.

- After the placenta comes – the mother will be watched for warning signs including excessive bleeding and signs of infection or toxemia.

- In the case of an unexpected or early delivery when the baby is coming too fast to arrive at the facility, the most important concerns are preventing life-threatening infection to the mother and baby and preventing severe or excessive bleeding. Anyone who is helping the mother with the delivery needs to thoroughly wash their hands with soap and water. The cord needs to be cut with a new razor blade and tied with a clean cloth or string. Make sure everything that comes into contact with mother and child is clean.
  - It is important for the mother and baby to go to a health care facility as soon as possible within the first 24 hours.

- Plan ahead – do not wait for warning signs to find out about emergency care and transport options.

**SESSION 3.6 Bonding as a father with the baby**

**Learning Objectives:**
- To have men think about ways they can support their partner in taking care of the baby after birth

**Time:** 10 minutes

**Facilitator Instructions:**
- Referring to the picture, ask men if it is common to see men playing with their babies or supporting women in caring for them. Also, what can they do to improve on the current support they give their partners?
- Review the key messages with participants.

**Key Messages:**
- Now that the baby has come, it is very important to spend time with your partner and the baby.
- Spending time with your partner and your baby after s/he is born is a good opportunity for bonding between father and baby, and as a family. This also helps the baby grow and develop healthfully.
• Support your wife or partner to breastfeed; help her to resist advice to give the baby other liquids, foods or herbs as it is unsafe for the baby to have anything other than breast milk for the first 6 months.

Discussion
How can men support their partners to care for the baby during the first few months?
Facilitator Note: If not raised, ask the men to inform all family members that the baby is on exclusive breastfeeding and hence should not be given any other foods or drinks.
Recap: In today’s session we talked about: Are you ready to be a father?!
• Discussing HIV prevention and safer sex with your partner
• Danger signs during pregnancy
• Importance of a facility-based birth
• Planning for a facility-based birth
• Labor and delivery
• Bonding as a father with the baby
In the next session we will review how men can ensure the health of their families.
Facilitator Note: Let participants know when and where the next session will be.

Session 4 Keeping Your Family Healthy

4.1 Importance of exclusive breastfeeding for the first six months of the baby’s life
4.2 Care for the mother following delivery
4.3 Danger signs in the mother after birth
4.4 Danger signs in a baby
4.5 Follow-up care for the mother and baby
4.6 Keeping the baby HIV-free - reducing the risk of HIV transmission from mother to baby
4.7 Family planning
4.8 Taking responsibility as men for the health of the family

Overall session time: 2-3 hours

Materials needed:
• Family planning IEC materials
• Condom demonstration kit – male and female if available

SESSION 4.1 Importance of exclusive breastfeeding for the first six months of the baby’s life

Learning Objectives:
• Help fathers understand what to expect for newborn care in the first few months
• Understand the importance of exclusive breastfeeding for the first 6 months

Time: 10 minutes
Facilitator Instructions:
Recap - In the last session we looked at: Are You Ready to Be a Father?! We looked at how men can support their partners and wives during pregnancy and childbirth.
In this session we will look at:
- Importance of exclusive breastfeeding for the first 6 months of the baby’s life
- Care for the mother following delivery
- Danger signs in a mother after birth
- Danger signs in a baby
- Follow-up care for the mother and baby
- Keeping the baby HIV-free
- Family planning
- Taking responsibility as men for the health of the Family

Discussion
Refer to the picture.
- Women often experience “advice” from others, often based on traditional practices, pressuring them to give the baby other foods, liquids, traditional herbs, etc. Men need to understand the danger in giving the baby anything other than breast milk for the first six months. You have a role as men to support your women to exclusively breastfeed and to resist advice that is risky for your partner to follow.
  - Have you experienced these pressures?
  - How have you dealt with them?
  - Share experiences of how to support your partner or wife to breastfeed.
- Review the key messages with participants.

Key Messages:
- Exclusive breastfeeding is where the baby has only breast milk for the first 6 months.
- Whether HIV-positive or negative, mothers should breastfeed. HIV-positive mothers need to be on Antiretroviral Therapy to ensure they do not transmit HIV to their baby in the breast milk. You can support your wife/partner to take ARV medication at the same time every day.
- It is important to protect your partner from advice to give the baby additional liquid, foods, herbs, gripe water, or tea. This is important because any other liquid besides breastmilk during the first 6 months can be harmful to the baby.
- If the baby has been prescribed medicine from the health facility, the medicine can be combined with breastmilk and given to the baby. Do not combine the medicine with water or any other liquid.
- Always visit your health care worker if there are any issues with breastfeeding.

Benefits of breastfeeding:
- Breast milk is full of important vitamins and nutrients for the baby. The gut of the newborn is very delicate, so breast milk is the best thing for them!
- Breast milk provides protection to the baby, protecting him/her from viruses, infections and illness.

Immediate breastfeeding also benefits the mother. It:
- Encourages bonding between mother and baby.
- Stimulates continued production of breast milk.
- Facilitates the delivery of the placenta (after-birth).
- Helps contraction of the uterus.

Extra support to the breastfeeding mother and baby:
- In the first few months of the baby’s life, frequent breastfeeding is normal – the mother will need to breastfeed day and night (approximately every 3 hours).
• All mothers produce enough milk to adequately provide for their infants, but a woman needs a balanced diet to produce milk and she also needs to rest to have enough energy for herself and to care for the baby.
• A breastfeeding mother needs to eat a variety of foods, including animal products (where acceptable and possible), fruits, and vegetables. A nutritious diet is a balanced one; breastfeeding mothers need to eat a selection of food including vegetables and fruits, carbohydrates and proteins.

Good foods for the breastfeeding mother include:
- Chicken liver, carrots, cooked greens, pumpkin, mango and other fresh fruit
- Goat, pumpkin and squash seeds, and peanuts
- Milk, and eggs
- Beef, liver, munga and beans
- Green leafy vegetables (cabbage, spinach, local greens)

Misconception: Sometimes in a family, food items such as meat or other protein items are reserved for the men in the family. It is important that these protein items be shared with women while they are pregnant and breastfeeding.
- If you are engaging in unprotected sex with multiple partners during this time, it is possible that you can pass HIV to your partner and then through her breast milk to the baby. Make the right choices and protect your child.

Facilitator Note: Link back to the men’s life goals they set in Session 1, as well as the different roles they said they have. Strong and responsible men make the right choices for the well-being of their families.

SESSION 4.2 Care for the mother following delivery

Learning Objectives:
- Understanding the changes a woman’s body experiences following the birth of the baby

Time: 10 minutes
Facilitator Instructions:
Discussion
- What is done traditionally to care for the newborn? i.e. care of the umbilical cord, fontanel, etc.
- The discussion will bring out points giving of herbs and tying beads around the baby’s neck.
- Response: The Peer Facilitator should dispel these traditional practices and emphasize that they are harmful to the baby.
- Emphasize: Babies should be given breastmilk to avoid dehydration.
- Review the key messages and picture with participants.

Key Messages:
- Care
  o Following the birth, keep the baby’s skin, cord stump and eyelids clean.

Facilitator Note: Emphasize that people should not use anything else to clean the umbilical cord stump. Herbs, cow dung, soot, spit, soil and other home remedies actually cause infection. The best way to clean the baby’s cord is to apply a mixture of cool boiled water and salt to the base of the umbilical cord’s stump, where it meets the baby’s stomach. Do not clean or interfere with the umbilical cord itself.
• The baby’s body should be carefully examined at least once a day to check that there is no rash, infection, etc.
• The fontanel, where the baby’s head is soft at the top, will close on its own, there is no need to do anything special. Trying to ‘shape’ the baby’s head will only traumatize the head. The front fontanel will close around 4 – 5 months and the back, after 6 weeks.
• Keep sick people away from your baby.
• If the baby feels cool – you or the mother should make skin-to-skin contact, cover the head and body, and the mother should breastfeed often.
• If the baby feels warm – you or the mother should stay with your baby in the coolest part of your home, loosen baby’s clothes, and bathe in lukewarm (not cold) water. Dry well and ensure the baby is breastfed often.
• After the birth, a woman continues to bleed until the uterus has fully healed.
• Bleeding can be heavy in the first few weeks following the delivery and gradually reduces as the uterus heals.
• After delivery it is important to avoid life-threatening infection in the womb and the birth canal.
• You should not have sex for at least the first 6 weeks or until the woman is comfortable because you need to wait for all bleeding to stop and for the uterus to heal.

Facilitator Note: Refer to picture with the following key messages to show where healing and potential infection can occur – in the womb and the birth canal and link that to the fact that sexual intercourse can cause trauma to the birth canal if it has not had a chance to heal. This is why 6 weeks is needed for the woman to heal before resuming sex.
• The 6 week visit to the health care facility is important as the midwife or health care worker needs to examine the woman and ensure the womb has completely healed.

Discussion
• How can men cope with supporting their partner as she heals from the birth of the child?
• Facilitate a discussion on coping mechanisms for men as they support their partners in healing following the birth of their child.
  o Abstinence
  o Mother goes back to stay with her family
  o Man/father busies himself with activities, such as exercise
  o Remind the men of the colors exercise about how easily HIV can be passed.
• Services received during visits include immunizations, growth monitoring, and developmental assessment of the child, checking for health problems, and testing for HIV infection.
• The child will receive an immunization card that should be kept clean and up-to-date – this will be necessary for school enrolment for the child. When you go to the clinic, make sure you bring your baby’s health card and yours.
• Discuss circumcision of male infants with your partner and the health care worker. Male circumcision is one way of reducing HIV infection. Between the age of 7 and 28 days is the recommended time for male circumcision.
• Make sure you help your partner follow the recommended visit schedule and take all medications as prescribed; follow the advice of health workers received during these visits.
SESSION 4.3 Danger signs in the mother after Birth

Learning Objectives:
• Understanding danger signs in a mother after birth and importance of seeking immediate medical attention if there are any danger signs

Time: 10 minutes

Facilitator Instructions:
• Review the key messages and picture with participants.
• Make sure they can recognise all of the danger signs a woman may experience after the birth of a baby.

Key Messages:
If your partner is showing the following danger signs after birth, ensure that your partner gets help from the nearest health facility immediately:

Facilitator Note: Refer to picture which shows the danger signs in a mother after birth. Many of these will be similar to the pregnancy warning signs, but some are different.

• Severe pain in the lower belly
• Swelling in face or hands
• Heavy bleeding – go to the health facility urgently if there is very heavy bleeding. Bleeding should gradually become less and completely stop by two weeks after birth.
• Severe headache, vision problems, fits
• Fainting or extreme weakness
• Fever
• Bad smell from the birth canal
• Hot, red or painful lump in breast
• Leaking urine or faeces
• Cannot pass urine
• In case of an emergency homebirth, if the placenta or afterbirth does not come out within 10 minutes after giving birth, seek immediate attention. The mother needs to go to the health facility immediately if she is not already there.

Facilitator Note: Emphasize the importance of a facility-based birth.

• Mood changes after birth are normal. This is most often related to hormones (the body’s natural chemicals that change during and after pregnancy), and is not a sign of bewitching. If it does not go away, it is a problem that needs attention at a health care facility. It may be post-natal depression. This affects many mothers and is not something to be ashamed of or hide from. If she feels she may hurt herself or her baby, she needs urgent help from a health worker.
SESSION 4.4 Danger signs in a baby

Learning Objectives:
- Understand danger signs in a baby and importance of seeking immediate medical attention if there are any danger signs

Time: 10 minutes

Facilitator Instructions:
- Review key messages and picture with participants.
- Make sure they can recognise all of the danger signs a baby may experience.

Key Messages:
If you notice any of the following signs or suspect something is not right - get help! Keep breastfeeding; keep your baby warm and dry.

Facilitator Note: Refer to picture that depicts the danger signs in a baby.

Danger Signs
- Feeding difficulties or refusal to breastfeed (can’t suck, weak sucking, stops feeding too soon).
- Baby underweight, under 2.5kg
- Continued vomiting, diarrhoea or fever
- Little energy (not active, not feeding, moves only when touched, limp)
- Baby too hot or cold
- Breathing difficulty (breathes slowly, nostrils widen, breathing fast, skin around ribs draws in)
- Fits or convulsions (jerky motions)
- Yellow eyes or skin
- Infected belly button, eyes or skin
- Bulging fontanel
- Cannot pass urine or feces

SESSION 4.5 Follow-up care for the mother and baby

Learning Objectives:
- Understanding the importance of health care facility visits for the mother-baby pair in the first two years

Time: 10 minutes

Facilitator Instructions:
• Review the key messages with participants. Emphasize: Encourage the men to also stay healthy for the better health of the family.

**Key Messages:**

- There is a whole schedule of health care facility visits for the mother and the baby for the first 5 years.
- These visits are more frequent in the first 2 years, especially the first 6 months:
  
  **Facilitator Note:** Refer to picture showing the 3 recommended PNC visits.
  
  - The 1st recommended visit for the mother-baby pair is within the first 6 hours of delivery if the mother and baby are not in the healthcare facility already. Care soon after giving birth is critical as most newborn deaths occur in the first 24 hours.
  - The 2nd visit should happen six days after delivery for all mothers and babies.
  - The 3rd visit should happen 6 weeks after delivery.

The visits will then follow the standard schedule for immunization for the baby.

- You may need another visit if your baby has been born early or with any other birth complications. You should follow advice you receive from the health worker.
- Statistic: Within the first month, 25% to 50% of all deaths occur within the first 24 hours of life, and 75% occur in the first week.
- These visits are very important for immunizations, growth monitoring, developmental assessment of the child, checking for health problems, and checking for HIV infection. The child will need an immunization card that should be kept clean and up-to-date, as this will be important later for school enrolment.
- Remind your partner to bring her antenatal card and the baby's health card during these visits.
- Discuss circumcision of male infants with your partner and the health care worker. Male circumcision is one way of reducing the risk of HIV transmission later in the man's life. Infant male circumcision is recommended to take place at 7-28 days of life.
- Make sure you help your partner follow the recommended health care facility visit schedule and encourage your partner to take medications as prescribed by the health care workers.
- Your support can help your partner follow the advice of health workers and resist pressures from others.

**SESSION 4.6 Keeping the baby HIV-free – reducing risk of HIV transmission from mother to baby**

![Image](image_url)

**Learning Objectives:**

- Understand that HIV transmission from mother to child can be prevented
- Encouraging men to take responsibility for keeping the baby free from HIV infection

**Time:** 10 minutes

**Facilitator Instructions:**

- Probing question: Refer to picture. Ask participants what they see.
- Response:
  - Support from partner in taking ARVs at the same time every day.
Breastfeeding having taken ARVs.

- Review the key messages with participants.

Key Messages:
- Mothers with HIV need to take extra care to reduce the risk of HIV transmission to their infants. There may be medicines that the mother and the baby need to take, including NVP syrup for the baby for six weeks, lifelong ART for HIV-positive pregnant and lactating mothers to prevent the transmission of HIV to their babies.
- Encourage your partner to join a mother’s support group, so that she can discuss her experiences as a new mom with other mothers.

HIV Testing
- Even for mothers and fathers that tested HIV-negative during ANC, HIV re-testing is important for the mother and the father throughout breastfeeding to ensure that any new HIV infection is detected.
- There is a period of time when a person first has HIV that they can test HIV-negative because the body has not had time to respond to the HIV yet. After a few weeks, the HIV test will be able to detect the HIV. This is called the ‘window period’. The person actually has HIV but the test doesn’t detect it yet. That is why retesting is important. The other reason is that continued sexual activity during pregnancy could expose you to HIV.
- Mothers or fathers who tested HIV-positive need to ensure that they are taking their ARVs as prescribed.
- Be sure that your baby receives HIV tests as recommended by your health care worker. The first test is usually at six weeks of age. The final test will occur 6 weeks after your partner stops breastfeeding, but your clinic may provide testing more often to ensure that any new infection is treated promptly.
- If a child is infected with HIV, the baby should initiate ART as soon as possible.
- Once a person tests positive they will always test positive, because they will always have HIV.
- If the mother has HIV, she should breastfeed exclusively for six months, then add complementary foods. At 12 months, it is usually recommended that she stop breastfeeding. She and her baby should continue taking their prescribed medications while breastfeeding. The risk of transmission through breastfeeding is very small, if the mother and baby are taking their medications and following the advice of the health care worker, this allows the baby to continue to get the important benefits of breastfeeding.
- Regardless of HIV status, you and your partner/wife should use condoms for protection from HIV, as well as a reliable family planning method during the breastfeeding period. Barrier methods, such as the male and female condoms are necessary to protect the mother from infections that could be passed to the baby through her breastmilk.

Facilitator Note: Link to next topic that will deal with family planning methods in more detail.
• Understanding the importance of making a mutual decision about when - and if - to have another baby
• Helping men to understand that there are a range of family planning options available, and encourage them to discuss what methods are best for their family planning intentions with their partner
• Reinforcing the importance of dual protection to prevent both an unwanted pregnancy as well as HIV/STI infection

Time: 5 minutes

Materials:
• Family planning IEC materials
• Condom demonstration kit – male and female if available

Facilitator Instructions:
• Probing question: What is family planning?
• Review the key messages with participants

Key Messages:
• Family planning is when an individual or couple makes an informed decision on when to have children (not too soon, and not too late), by either using a birth control method with guidance from a health worker or by not using a birth control method when wanting to conceive.
• Before resuming sex after pregnancy, it is important to discuss family planning with your partner because a woman’s body needs time to rest and heal in between child births and pregnancy.
• You should talk to your partner about when and if you want to have your next child and make a mutual decision.
• During the breastfeeding period, you should have a plan for dual protection with your partner, meaning protecting against both another pregnancy as well as using a condom for prevention of a sexually transmitted infection, regardless of your HIV status. There are many family planning options; some are short-term, some are long-term and some are permanent.
• It is harmful to the mother’s health to have babies too close together. Waiting for two years is the recommended interval.

Facilitator Note: Refer to picture to review main family planning methods. The picture shows dual protection, using 2 types of protection, against STIs and for family planning. This is the safest and best approach to keep your baby safe.

<table>
<thead>
<tr>
<th>METHOD</th>
<th>DESCRIPTION</th>
<th>HOW IT WORKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pills – Combined oral contraceptives or “the pill”</td>
<td>Contains two hormones</td>
<td>Prevents the release of eggs from the ovaries (ovulation)</td>
</tr>
<tr>
<td>Progestogen only pills or “the minipill”</td>
<td>Contains one hormone</td>
<td>Thickens cervical mucus to block sperm and egg from meeting and prevents ovulation</td>
</tr>
<tr>
<td>Implants</td>
<td>Small rods or capsules placed under the skin of the upper arm; contains one hormone only</td>
<td>Thickens cervical mucus to block sperm and egg from meeting and prevents ovulation</td>
</tr>
<tr>
<td>Monthly injectables or combined Injectable contraceptives</td>
<td>Injected monthly into the muscle, contains two hormones</td>
<td>Prevents the release of eggs from the ovaries (ovulation)</td>
</tr>
<tr>
<td>Coil (IUD)</td>
<td>A T-shaped plastic device inserted into the uterus that releases small amounts of the hormone</td>
<td>Suppresses the growth of the lining of the uterus</td>
</tr>
<tr>
<td>Male condoms</td>
<td>A sheath that fits over a man’s erect penis</td>
<td>Forms a barrier to prevent sperm and egg from meeting</td>
</tr>
<tr>
<td>Female condoms</td>
<td>A sheath, that fits loosely inside a woman’s vagina, made of thin, transparent, soft plastic film</td>
<td>Forms a barrier to prevent sperm and egg from meeting</td>
</tr>
<tr>
<td>Male sterilization (vasectomy)</td>
<td>Permanent contraception to block or cut the tubes that carry sperm from the testicles</td>
<td>Keeps sperm out of ejaculated semen</td>
</tr>
</tbody>
</table>
**Female sterilization (tubal ligation)**

Permanent contraception to block or cut the tubes that supply the egg

Eggs are blocked from meeting sperm

**Withdrawal**

Man withdraws his penis from his partner’s vagina, and ejaculates outside the vagina, keeping semen away from her

Tries to keep sperm out of the woman’s body, preventing fertilisation

**Moonbeads**

Calendar-based methods: monitoring fertile days in menstrual cycle; symptom-based methods: monitoring cervical mucus and body temperature

The couple prevents pregnancy by avoiding unprotected vaginal sex during most fertile days, usually by abstaining or by using condoms

**Facilitator Note:** Men may ask more in-depth questions about various family planning methods – facilitator should be equipped with basic IEC materials or talking points from the country programme on available methods, but refer participants to health professions/facilities for more detailed information.

**Demonstration – Male condom**

Facilitator should be prepared to do a condom demonstration. (Ask a health professional to provide the demonstration for the female condom).

- Ask participants: "Who has seen a condom demonstration before?"

**Facilitator Note:** Refer to image – read through following instructions that accompany the image.

Encourage a volunteer from the participants to do the demonstration but if a mistake is made, the Peer Facilitator needs to demonstrate the right way!

1. Use a new condom in a sealed packet. Check the expiration date on the packet.
2. Condom package must be torn open carefully, so as not to damage the condom. Fingernails and jewelry can also damage condoms. Use only one condom.
3. Put the condom on after the penis is erect and before any sexual contact. Unroll the condom a little (about ½ inch) and then hold it by pinching the tip with the fingers of one hand.
4. Fully unroll the condom down the entire shaft of the penis to the base. Either partner can do this.
5. Pull the penis out immediately after ejaculation by holding onto the base of the condom first. The condom should be removed away from one’s partner.
6. The used condom is thrown away. Condoms should never be used more than once.
   - It is important to have a conversation with your partner about when you would like to have another child before you start resuming sex; you don’t want to be discussing this in the heat of the moment!
   - You can get more information about each available family planning option for you and your partner at the health facility
   - It is important to prevent pregnancy and STIs; even if your partner is on a family planning method, this does not stop the transmission of STIs. Use a condom to prevent STIs or, if infected with an STI, seek medical attention with your partner.

**SESSION 4.8 Taking responsibility as men for the health of the family**

**Learning Objectives:**
- Men are encouraged and empowered to take responsibility for their own health and the health of their families.

**Time: 10 minutes**

**Facilitator Instructions:**
- Probing question: What can a man do to protect the health of his family?
- Review key messages and picture with participants

**Key Messages:**
- As a man you have a responsibility for protecting your own health, as well as helping to keep your family healthy.
- Examples of healthy practices include: Safer sex including using condoms and avoiding multiple sexual partners; retest for HIV if you are at risk; if you or your partner are already on ART, make sure you take your medications as prescribed by the health care worker; check your BP and blood sugar.
- Eat a healthy, balanced diet and avoid excessive alcohol intake and smoking.

*Facilitator Note: Refer to picture – shows importance of communication – importance of talking with your partner at home as well as going to the health facility together.*
- Behaviours outside of your home can have an impact on your health and your family’s health – as we learnt with the sticker exercise.

**Recap - What was covered today**

*Keeping Your Family Healthy*
- Importance of exclusive breastfeeding for the first six months of the baby’s life
- Care for the mother and newborn after delivery
- Danger signs in a mother after birth
- Danger signs in a newborn
- Follow-up care for the mother and the baby
- Keeping the baby HIV-free
- Family planning
- Taking responsibility as men for the health of the family

**Final Wrap-up of All Sessions**

Thank you for taking part in these sessions on how men can support and be involved in maternal, newborn and child health. The 4 sessions have covered:
1. Strong informed, powerful men as champions for healthy families
2. Ways in which men can support the health of the pregnant wife and unborn child
3. How men can ensure the health of their partners/wives and babies during childbirth
4. Ensuring the on-going health of the family

**Discussion**

What have men learnt through participation in these classes?
Facilitate a discussion on what men have learnt from participating in these four sessions.
Suggested questions to start the discussion:
1. How have your views on the importance of men’s health changed through your participation in this group?
2. How have your behaviours changed?
3. What changes do you plan to make in the future to protect the health of your family?
4. Has your relationship with your partner changed? Are you more prepared to have difficult conversations with your partner?

- Outline next steps that participants can take:
  - Put into practice what you have learnt in these sessions.
Encourage your peers to attend these sessions.
Form peer groups back in your community to provide continued support. (Extra support to groups outside of these sessions cannot be provided).

**Reference Section**
Common discomforts experienced by pregnant women and ways to alleviate them:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MORNING SICKNESS/NAUSEA</strong></td>
<td>Eat smaller meals more frequently, instead of several big meals.</td>
</tr>
<tr>
<td><strong>HEART BURN</strong></td>
<td>Avoid spicy foods and eat frequent, small meals. Do not lie down immediately after eating</td>
</tr>
<tr>
<td><strong>CONSTIPATION</strong></td>
<td>Drink water, eat vegetables and fruits.</td>
</tr>
<tr>
<td><strong>VARICOSE VEINS</strong></td>
<td>Prop up feet when sitting; avoid standing for long periods of time.</td>
</tr>
<tr>
<td><strong>HAEMORRHOIDS</strong></td>
<td>Avoid sitting for long periods; eat fruits and vegetables</td>
</tr>
<tr>
<td><strong>VAGINAL DISCHARGE</strong></td>
<td>The normal fluids in the vagina tend to increase during pregnancy. This is nothing to worry about unless the discharge becomes greenish, yellowish, or bubbly, and is accompanied by itching or an unpleasant odour, in which case you should seek treatment at a clinic.</td>
</tr>
<tr>
<td><strong>BACKACHE</strong></td>
<td>Keep back straight when sitting and standing; do exercises. Wear low-heeled shoes. Rest should help as well.</td>
</tr>
<tr>
<td><strong>LEG CRAMPS</strong></td>
<td>Stretch the muscle out slowly by straightening the leg and pointing the toe back. Balance periods of exercise with periods of rest during the day.</td>
</tr>
<tr>
<td><strong>MILD SWELLING IN ANKLES AND FEET</strong></td>
<td>Avoid tight clothing, shoes, and jewelry. You can relieve swelling by resting on your left side, and elevating your feet several times a day. If the swelling is sudden or if you have swelling in the face, go to a clinic immediately.</td>
</tr>
<tr>
<td><strong>SHORTNESS OF BREATH</strong></td>
<td>If prolonged, go to a health facility</td>
</tr>
<tr>
<td><strong>ABDOMINAL PAIN AND CRAMPING</strong></td>
<td>Drink fluids to prevent the pain. Sit or lie down when the pain strikes. If it is prolonged or does not subside, go to a clinic.</td>
</tr>
<tr>
<td><strong>URINARY DISCOMFORT</strong></td>
<td>Drink lots of water and urinate often. If there is pain, go to a health facility.</td>
</tr>
<tr>
<td><strong>HIP PAIN or PELVIC BONE PAIN</strong></td>
<td>Rest and tell a health worker at your next ANC visit. If the pain is severe, seek help at a health facility</td>
</tr>
</tbody>
</table>
Manual of Standard Operating Procedures for Peer Groups Intervention

EGPAF Staff SOPs

The EGPAF Staff SOPs outlines the procedures and processes by which the MNCH and Male Peer Groups should be implemented. This document summarizes the roles, and responsibilities, of staff in training and mentoring the peer facilitators. The training components include how to recruit, register and train peer facilitators. It also outlines how peer facilitators should manage registration, participation and attendance of group members.

Peer Group Facilitator SOP

The Peer Group Facilitator SOP provides a guideline for the roles and responsibilities of the peer facilitators. This SOP summarizes the processes by which the peer facilitators should conduct participant recruitment, registration, managing meetings, referrals, withdrawals and group members.

Peer Group Forms Combined

This document holds all of the forms, will be used for managing the peer group meetings. It includes forms for both the peer facilitators and participants such as registration, attendance, learning needs, training, workshops and mentorship plans. These forms allow the peer facilitators to track and document all the activities that will be conducted during the peer group meetings so as to measure the impact of the intervention.

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Introduction

I. Purpose of the SOPs
These SOPs provide detailed guidance to help ensure standardized implementation of the MNCH and Male Peer Groups. Both the MNCH and Male Peer Groups are a series of four structured, peer facilitated sessions on topics related to MNCH, gender and PMTCT to provide support to pregnant and breastfeeding women and their partners to achieve positive health outcomes for themselves and their families.

These SOPs address the activities the peer facilitators are expected to complete as part of the implementation of the peer groups. These SOPs cover group member recruitment, implantation of the modules, assessment, and data collection activities for the peer groups. The SOPs are intended to be used along with other research and implementation resources to ensure that each country team executes the intervention according to the set quality standards.

II. **Target audience for these SOPs**

These SOPs are intended to be used by peer facilitators and other stakeholders that will be engaged in the implementation of the MNCH and the Male Peer Groups in Swaziland, Uganda, and Zimbabwe.

III. **Terminology**

**MNCH Peer Groups**

The MNCH Peer Groups provide 10 – 15 women, non-pregnant, pregnant and breastfeeding women with an opportunity to share their experiences, share coping strategies, learn new knowledge, jointly problem-solve, and positively influence each other with support from a trained facilitator of the same gender.

**Male Peer Groups**

The Male Peer Groups provide 10 – 15 men of reproductive age with an opportunity to share their experiences, learn new knowledge, jointly problem-solve, and positively influence each other on issues related to gender, fatherhood, and the man’s role in ensuring a safe motherhood experience to his partner birth preparedness with support from a trained facilitator of the same gender.

**MNCH Peer Group Facilitators**

Individuals who receive orientation and are equipped to lead structured discussions within small dialogue groups during the Community Days. A facilitator should be a person with good communication and facilitation skills, discretion, recent experience in the ANC/PMTCT context and familiarity with health issues in the community (especially MNCH). Staff or volunteers from the R/DHMT, MOH, NGO, CBO, etc., can be equipped for this role.

**Male Peer Group Facilitators**

Individuals who receive orientation and are equipped to lead structured discussions within small discussion groups. A facilitator should be a person with good communication and facilitation skills, discretion, recent experience in the ANC/PMTCT context, influencing skills, and familiarity with health issues in the community (especially MNCH). Staff or volunteers from the R/DHMT, MOH, civil society, etc., can be equipped for this role.
Informed Consent

Informed consent is the process by which a peer group member voluntarily confirms willingness to participate in the study. This is after s/he has been told about and understood the purpose, risks, and benefits of participating in the study. The decision to participate is documented in a written informed consent form, which the participant has signed and dated.

Figure 1. Peer Facilitator SOP Flow Chart

SOP CC-0: Peer Facilitator Roles & Responsibilities

I. Purpose
The purpose of this SOP is to provide overall guidance on the roles and responsibilities of Peer Facilitators (PFs) in this study.

II. Roles and Responsibilities of Peer Facilitators
1. Attend and actively participate in training sessions.
2. Understand and be familiar enough with the session materials to lead MNCH and Male Group Sessions.
3. Work closely with EGPAPF staff regarding peer group meeting logistics and preparations.
4. Participate in the recruitment of eligible individuals into the peer groups.
5. Meet with community leaders and clinic staff to get their support and assist with referrals.
6. Enroll men and women into the study and correctly complete the proper enrollment forms.
7. Schedule and conduct peer group meetings using assigned materials.
8. Actively protect confidentially of all participants.
9. Fill out attendance forms.
10. As necessary, conduct one-on-one meetings as requested by group participants.
11. Follow-up with individuals who missed a meeting and schedule potential catch-up meetings.
12. Meet regularly with the [EGPAF Staff] to report back on meetings, attendance, any challenges that may arise, etc.

**SOP CC-1: Recruitment of Peer Group Members**

I. **Purpose**
   The purpose of the SOP is to provide guidance on how peers will be approached and recruited into the peer groups.

II. **Roles and Responsibilities**
   1. EGPAF staff and each Peer Facilitator (PF) are responsible for recruiting participants who meet the criteria for the groups, through the methods outlined below.
   2. EGPAF Staff is responsible for communicating regularly with the PFs to ensure recruitment is taking place and to address any challenges at hand.

III. **Procedures**
   1. PFs and EGPAF staff should plan recruitment for their clusters together; although recruitment for the first group may take place by the EGPAF staff to ensure that there is enrollment for the PFs when they complete the training.
   2. Women can be recruited for the community, during general referrals from Antenatal Care (ANC) clinics, by community leaders, through community health workers (CHWs) / VHTs, from local water points, and churches, among others. Interested individuals should be entered into the Group Members Sign Up form. Ensure that all contact information is obtained so that individuals can be contacted about the group meetings.
   3. Women to be recruited should meet the following criteria:
      a. Age 16 and above
      b. Pregnant, non-pregnant and breastfeeding
      c. Reside in the community
   4. Men will be recruited from numerous entry points, including through general referrals from VCT points, STI clinics, HIV care and treatment services, by community leaders, or through community health workers/VHTs, RHMs, and churches. Men to be recruited should meet the following criteria:
      a. (16 and above)
      b. Reside in the community
   5. Peer Facilitators should visit the sites on the day and time that will be most likely to have the highest number of eligible individuals present.
   6. Peer Facilitators should continue to visit these sites until the target for group members has been reached.
   7. At the recruitment sites, the peer facilitators should approach individuals in small groups and tell them that s/he would like to talk to them about a new program in the community for healthy pregnancies and families. The PF should use the recruitment guidelines shared by the [EGPAF Staff] to inform people of the meetings. After sharing the information, the PF should be sure to answer any questions, but also to encourage them to come and learn more at the first meeting.
   8. If there are challenges in the identified locations, or people are not showing an interest in participating, the PF should contact the [EGPAF Staff] as soon as possible.
9. Planning the Consenting and Enrollment meeting:
   a. EGPAF staff and PF should list all individuals who will be invited for each meeting on Form FCC1-3 and decide on a place and time for the initial group meeting for informed consent and registration.
   b. The PF must coordinate with EGPAF staff on dates and locations of registration so that the KAPB Lite survey can be administered at the same time.
   c. When selecting a location for the meeting, the following criteria should be considered:
      • Private: where a group conversation will not be overheard
      • Convenient: not too far from where peers reside
      • Comfortable: shade available
   d. Once the dates and location for the registration and enrollment meeting are agreed, use Form FCC1-2, the Planning Checklist, to guide the planning.
   e. The PF will contact each individual and invite them to the meeting at least one week in advance, explaining that this will be an informational session where the individual can learn about the group and complete their enrollment before the sessions officially begin.
   f. The PF should identify the time and location of the subsequent meetings for each group and use Form FCC1-2, the Peer Group Planning Checklist, as a guide.

IV. Resources
1. FCC1-1 Group Members Sign-up form
2. FCC1-2 Peer Group Planning Checklist
3. FCC1-3 Peer Group Consenting and Enrollment Meeting Participant List
4. Appendix B of Recruitment Guide (to be created by country team)
SOP CC-2: Conducting the Consenting and Enrollment Meeting

I. Purpose

This SOP sets out the procedure for obtaining informed consent from the women/men who are willing to participate in the MNCH and Male Peer Groups. Informed consent should be done 1-2 days before the first meeting.

Definition of informed consent:

Informed consent is the process by which an individual (i.e. a man or woman) voluntarily confirms their willingness to participate in the peer groups. This is after s/he has been told about and understands the purpose, and benefits of the peer group sessions. Her/his decision to participate is documented in a written informed consent form, which s/he has signed and dated.

II. Roles and responsibilities

1. The EGPAF staff is responsible for obtaining informed consent from each individual before they participate in the groups.
2. EGPAF staff is responsible for proper and safe (locked) storage of all participant informed consent forms.
3. The Country Project Coordinator and Principal Investigator have overall responsibility for ensuring that informed consent is obtained in a proper manner through the [EGPAF Staff].

III. Procedures

1. The PF should arrive at the designated meeting place for the enrollment process approximately 30 minutes in advance.
2. The PF should identify the time and location of the subsequent meetings for each group. The same meeting location can continue to be the meeting location, or the group can discuss and select another location.
3. EGPAF staff and PFs should ensure that they prepare ahead of the session:
   a. The list of expected individuals who have been referred (From FCC1-3).
   b. Additional copies of the key forms, including consent forms, registration forms, and attendance registers.
4. Give an overview of the group process in a group environment. This overview should include the purpose, what is being requested of the participant, the procedures (how the group sessions will be managed), what risks s/he may face as a result of participating, and the benefits of participating.
5. Data collector should read the consent form slowly and clearly. Explain that their participation is completely voluntary and that if there is something that they are not comfortable with, they will not lose any services they would normally get from the clinic if they decide not to participate. Explain the benefits.
6. Data collector should take extra care and time in explaining the groups so that they are clear. Give the participants enough time to understand what the group is about and what is being asked of them. Encourage them to ask questions.
7. Data collector should take individuals aside privately (out of hearing) and ask if they have any questions regarding the peer group or the consent process. If they must, you
can allow them to take the informed consent form home to discuss with their family, but be sure that this form is brought back before the participant joins the group.

a. If the individual is willing to join the classes, s/he should sign and date the informed consent form in ink, not in pencil. The signing is important because it verifies that the peer group overview was given to the participant, that s/he understood the information provided and that his/her informed consent was freely given and accepted. **Two copies of the informed consent need to be signed.**

i. If the participant cannot read and understand the consent form, the informed consent must be read to the individual in the presence of a witness who is literate and can verify that all the information in the form has been read to the individual.

ii. If the participant can write her/his name and date, s/he can sign on the appropriate line on the consent form. If s/he cannot write, s/he should place an “X” in the signature area and leave the date line blank.

b. If the individual is not willing to join the peer group, the informed consent process stops there, and the participant is free to leave. The peer facilitator will need to document the refusal and the reason on the peer group consent and the registration meeting list.

c. If the individual does not meet the criteria, thank them for their willingness to participate and refer any women to the health facility for their pregnancy care.

8. The witness will complete the information in the witness section of the consent form including the participant name and date.

9. You will then give the copy of the signed and dated consent form to the participant to keep, while you keep the original.

10. The peer facilitator should place the original in a file folder, which s/he will need to keep secure in her/his bag or in a place where unauthorized people may not have access to it. The form must not be left lying around in the open, where people, children and animals may accidentally or on purpose come upon it. The completed informed consent forms are confidential documents and must not be shared with anyone outside of the project. Once the informed consent process has been completed and the participant has signed, the participant can be registered into the group.

11. On collection, the [EGPAF Staff] will check the informed consent forms to make sure that they are signed and dated properly. The supervisor will file the informed consent forms in a lockable file cabinet in the office. The informed consent forms will need to be available for inspection by project monitors at any time.

12. The informed consent form will be stored for three years after the end of the peer group intervention and be available for audit after the end of the peer group intervention.

### IV. Resources

Form FCC2-1 Informed Consent Form
SOP CC-3: Registration of MNCH and Men’s Peer Group Participants

I. Purpose

All participants must be registered and assigned an ID number in order to join the peer group. This SOP will provide guidance to the peer facilitators on how to complete the participant registration process.

II. Roles and responsibilities

Peer facilitators will:

1. Assign a unique ID number to each peer group participant according to the range of numbers assigned to each PF.
2. Work with EGPAF staff to understand the instructions to correctly complete the registration forms and process.
3. Ensure that the participant demographic information is thoroughly documented.
4. Complete a registration form for each participant.
5. Submit forms in a timely manner to designated EGPAF staff.

III. Procedures:

1. The facilitator should fill out a registration form for each participant, Form FCC3-2 and FCC3-3.
2. G2. General instructions for completing forms:
   a. Forms should be completed in a blue or black pen and never in pencil.
   b. A form should be completed for each participant. When there is a box, use a tick mark to select the appropriate option.
   c. Do not leave any boxes blank.
   d. Keep all forms in your home in a safe location (in a drawer out of sight or in a safe place, or another place discussed with the [EGPAF Staff]) until collection by [EGPAF Staff].
   e. Once the participant has completed the informed consent, the registration should be completed. To complete a registration form:
      i. Fill in the participant’s name on the Peer Group Attendance Registration Form. Then fill in the participant’s name on either the Male or Female Participant Registration Form FCC3-2/3. Fill in the assigned participant number. The ID number now includes the group number followed by a dash and the participant number.
      ii. Write the ID number on the registration form. This is very important.
      iii. If the participant is a woman, make sure that you ask her to bring her ANC card so you capture her ANC number. Ask her the name of the facility where she attends ANC, the facility where she plans to deliver and the facility where the infant will receive follow-on care. This is also very important. If the woman does NOT have an ANC number for her pregnancy, that is okay. Leave the section blank, but keep this form for the woman until you have obtained the ANC number.
iv. Double check the registration form to make sure it is completed correctly before finishing the registration process.

v. Make sure that the participant information is correctly ticked on the participant list for the meeting.

vi. Submit forms in a timely manner to designated EGPAF staff.

IV. Resources
1. Form FCC3-1 Peer Group Participant Attendance Register
2. Form FCC3-2: Male Participant Registration Form
3. Form FCC3-3: Female Participant Registration Form
SOP CC-4: Conducting Peer Group Meetings

I. Purpose

This SOP sets the procedure for conducting peer group meetings.

II. Roles and Responsibilities

The Peer Facilitator will:

1. Communicate meeting dates, times, and venues with participants in advance.
2. Work with EGPAF staff on logistical preparations.
3. Faithfully execute the group discussions according to the curriculum instructions.
4. Complete participant attendance registration at the start of every session.
5. Inform the participants that the meetings will be held bi-weekly.
6. Hold individual meetings with participants as necessary.
7. Fill out a session report in the Peer Facilitator Session Report Notebook after each meeting.
8. Fully document all issues encountered during session.

III. Procedures

1. PFs should remind participants of the venue, date and time a few days prior to the group session.
2. PFs should ensure that they prepare ahead of the session:
   a. A list of individuals who have registered or have been referred.
   b. Supplies needed for the specific session, including learning materials, stationery, and additional copies of the key forms.
   c. PFs and the [EGPAF Staff] should ensure that they arrive at the venue at least thirty minutes ahead, in order to prepare the meeting venue and ensure last minute logistics are in place. This should include organizing the seating to foster positive group dynamics.
3. When participants arrive:
   a. Warmly welcoming participants as they arrive.
   b. Check to ensure that participants have registered, been assigned an ID, and been assessed prior to the meeting. If not done, ensure that it is completed before the session begins.
   c. Ensure that all group participants sign in using the attendance register, FCC3-1.
4. The session should be held as long as at least one person shows up. Participants may have travelled long distances for the meeting, so all scheduled meeting should be held.
5. For the first meeting, PFs should open the meeting by:
   a. Welcoming the participants and emphasizing that they are taking an important first step towards having a healthy family.
   b. Introducing themselves, including their name and residence area role.
   c. Introducing EGPAF and any supporting EGPAF staff, including their name and title.
   d. Asking participants to share why they are here and explain the peer group process.
   e. Asking if there are any questions about the group meetings.
f. Remembering to mention that there are corresponding peer groups for the opposite gender, and informing participants of the benefits of having their partners attend the corresponding peer group, especially if they are a couple expecting a child.

6. Participants may reveal personal information during a session. All participants should be reminded that this personal information must not be shared outside the group. A participant’s HIV status is highly personal, and if it is mentioned it the group, it should not be disclosed to anyone else at all. It is highly important that PFs protect this personal information. Never assume that an HIV positive individual has disclosed her status to a third party, including family members, unless s/he specifies that s/he has done so. Never discuss an HIV positive person’s status with anyone, unless s/he expressly approves this or initiates it.

7. For subsequent sessions:
   a. Reintroduce yourself to the group, and introduce any supporting staff, including their name, title and role.
   b. Remind participants of the ground rules.
   c. Remind participants that this is a closed group and explain the importance of keeping the group closed. Explain that participants can refer anyone who qualifies, for participation in another group.
   d. Start off each meeting with a brief recap of the last meeting. Ensure that participants have the opportunity to share their experience, following-up on any tasks that were recommended during the previous session.
   e. If a participant joins mid-way through the session, acknowledge their presence, give a brief summary of what has been covered, and continue the session.

8. Follow the instructions for the specified Module discussion topic, as outlined in the curriculum.

9. After wrapping up the session, explain to participants that you are available for individual sessions (brief sessions to answer questions and address concerns, and longer sessions to go over material they may have missed or do not understand).

10. Continue for four (4) sessions.

11. Take note of the length of the session. If the session(s) is/are longer than initially recommended, this is acceptable as long as the participants are in agreement. If the session(s) is/are shorter than planned, note this and discuss with the [EGPAF Staff].

12. Take note of any participants who were missing and follow-up with them.

13. Remember to store any forms out of sight during the sessions. Afterwards, store the forms in a safe place where others will not find them.

14. Before ending the meeting, PFs should ensure that:
   a. Participants are clear on the date and time of the next meeting.
   b. Participants who have any questions are attended to.
   c. Participants who may require a referral to other health and social service providers are attended to.
   d. Participants learn about the concurrent sessions for men/women, and participants who would like their spouse/partner to attend the concurrent/corresponding peer group are noted and given the pertinent recruitment information.
   e. Attendance registrations have been completely filled out.

15. PFs should take care to note any deviations from the recommended structure, such as spending more time on the session, omitting particular modules, etc.

16. The PF Session Report notebook has been completely filled out.
IV. **Resources**

1. Form FCC3-1 Peer Group Attendance Register
2. Form FCC4-2 Peer Facilitator Session Report Notebook
3. Implementation materials including manuals and flip charts
I. Purpose

Facilitators will be expected to refer participants who have not completed critical health visits, or who express specific social supports. The purpose of these SOPs is to provide guidance to peer facilitators on the referral process and its documentation.

II. Roles and Responsibilities

Peer Facilitator will:

1. Identify and refer participants who indicate that they have missed or are delaying specific health visits to CHWs, community leaders, or health facilities.
2. Counsel and refer participants
3. Refer participants for specific social supports that may contribute to better health and psychosocial outcomes for themselves and for their babies

[EGPAF Staff] will:

2. Follow-up to ensure that peer facilitators are not attempting to handle or address issues for which they are not equipped.
3. Track and monitor referrals by peer facilitators to ascertain what occur at health facility level when women are referred for health services.

III. Procedures

1. Some participants may indicate that they have not completed important health visits and milestones in their clinical care, which may place themselves and/or their babies at risk. If such a case occurs, refer these participants to the nearest health facility or to a Community Health Worker. Ensure that this is well documented, so that follow-up can occur at higher levels.
2. Some participants may disclose personal issues that PFs are not equipped to handle, such as violence in the home, dealing with a recent HIV positive result, need for food assistance, etc. In a case like this, it is best to refer them to the appropriate health or social service, where professional counseling and support is available.
3. Fill in a Health Services Referral form and tear along the dotted line. Give the top part to the participant and the bottom part to the Peer Facilitator Supervisor.

IV. Resources

1. FCC5-1: Community-Facility Referral Form EGPAF Peer Groups
2. Service directory created in country
SOP CC-6: Handling Missed Group Meetings

I. Purpose

This SOP sets out the procedure for following up and reporting on participants who miss support group meetings.

II. Roles and responsibilities

The Peer Facilitator is responsible for documenting when participants miss a group meeting.

III. Procedures:
1. If a participant misses a scheduled meeting, note this on the meeting register form.
2. Steps for documentation of missed appointment:
   a. On the Attendance Register, write the date and the signature of the participant who missed the meeting.
   b. If a participant misses two consecutive meetings, you should follow-up to find out if there is a problem and to determine whether or not the individual can rejoin the group. You should:
      i. Find out from the other group members if they know what has happened to her/him.
      ii. Phone her/him if she has a cell phone number. Try reaching him/her five times.
      iii. Go to his/her home, if you are unable to reach her/him by phone.
   c. On the Missed Peer Group Form, write down all the actions you take to contact the individual, the dates when they occurred, and whether you found her or not.
   d. If you do find her/him, discuss the reasons for missing the meeting and see whether they intend to continue. Write the date and the participant must sign on the one on one column on Form FCC4-1 Peer Group Attendance Register.
      i. If they want to continue, set up a time to review the missed materials.
      ii. If not, complete the Termination of Study form (see next SOP).

IV. Resources
1. Form FCC3-1 Peer group attendance register
2. Form 5 Study Termination
**SOP CC-7: Withdrawal from Study**

I. **Purpose**

The purpose of this SOP is to set the procedure for documenting and reporting participants who drop out of the MNCH and the Male Peer Group or to provide notification that they no longer intend to participate in the group.

**Definition of Withdrawal from the Study:**

Withdrawal from the study refers to participants who are no longer participating or who wish to withdraw from the study. Withdrawal can be informal or formal. Informal termination is when participants no longer attend the support groups; they may or may not give a reason for their lack of attendance. Formal termination is where the participant gives notice that he/she wishes to withdraw from the study.

If many participants withdraw from the study, whether formally or informally, this may mean that the groups are not seen as beneficial or their participation is causing them problems in some way. It may also affect that study so that the project may not realize its goals or purpose. It is important therefore to be aware of the number of terminations from the Peer Groups, and review the reasons for the termination so that necessary actions can be taken to prevent participant harm and ensure that the MNCH or Male Peer Group activity will not be negatively affected.

II. **Roles and responsibilities**

The Peer Facilitator will:

1. Document early withdrawals from the study
2. Fill in the information on the Group Attendance Registers
3. Ensure that the Study Termination form is given to the supervisor at the next meeting
4. Discuss issues related to early withdrawals with the supervisor as necessary.

III. **Procedures**

**Formal Termination**

1. If a participant informs you that s/he wishes to withdraw from the peer group sessions, you should complete the following on the Termination Form:
   a. Write date the request was made; write the day, month and year, in the space provided.
   b. PF number; participant registration number; and reason for termination.
   c. If you are able to find out the reason(s) why the participant has terminated from the group, you should write this in the space provided. This may give information on how the project is being perceived and if there are any potentially negative consequences of the project.
   d. Sign and date the form in the places indicated upon completion.
   e. Place the form in a file folder in a place where unauthorized people may not have access to it. Give the form to the supervisor when s/he comes on
his/her visits. S/he will check the form and make sure that it has been correctly completed before s/he takes the form to the office.
f. In the office, the termination form will be kept in a lockable file cabinet separate from the informed consent forms.
g. The forms must be kept for a minimum of three year after the end of the study.

Informal Termination

1. If a participant has missed two sessions without explanation, the “Termination from Study” form must be completed in the way described above. If you know the reason for her/his withdrawal from the study, you should write it in the appropriate place. If you do not, leave the section blank.

IV. Resources

1. Form 5 Study Termination form
I. Purpose

The purpose of this SOP is to provide guidance on communication with your supervisor, the Peer Facilitator Supervisor (PFS). The EGPAF STAFF is the EGPAF staff who provides support for you and can provide guidance in situations when you are not sure what to do.

II. Roles and Responsibilities:

The Peer Facilitator will:

1. Meet with TRAINING staff for regularly scheduled meetings
2. Provide completed forms to TRAINING staff

III. Procedures:

1. For the first month you will meet with the EGPAF staff every two weeks.
2. Starting in month two you will only meet with EGPAF staff once a month.
3. You should keep the completed project forms safe in your house until it is time to meet with the Peer Facilitator Supervisor. Do not travel around with the documents. If you have questions about the forms, ask the EGPAF staff. Give the EGPAF staff the following forms:
   a. Completed Peer Group Attendance Register (with enrollment numbers)
   b. Completed PF Session Report Notebook
   c. Peer Facilitator Monthly Tally Form
4. You may meet with the PFS in small groups based on your location. Your meeting with the PFS may include other peer facilitators from your community or from other communities depending on where you live.
5. You should reach out to the EGPAF staff whenever you have any issues or concerns. EGPAF staff is here to support and help you. The PFS’s cell phone number will be provided to you during your training. You will be provided with cell phone credit so that you may call the EGPAF staff when you need to.
   Below are some examples of issues that you should reach out to the EGPAF staff for:
   a. Any kinds of problems with the group meetings
   b. Any problems with individual participants
   c. If any personal problems arise for your participation as a peer facilitator
   d. Lots of participants are missing the group meetings
   e. You run out of forms or you fill your diary and need a new one
   f. Any challenges occurring in the community that affects your ability to conduct the group meetings.
6. The first person to contact is the EGPAF staff. But if you cannot reach the EGPAF staff and it is an emergency, you should contact other EGPAF staff with the phone numbers provided in the adverse events SOP.

IV. Resources

1. Form FCC 9-1 Peer Facilitator Monthly Tally Form
2. Form FCC3-1 Peer Group Attendance Register
3. Form FCC4-2 Facilitator Session Report
SOP CC-9 Closing out a Group

I. Purpose
This SOP describes the process for closing the group upon completion of the four sessions.

II. Roles and Responsibilities
Peer Facilitator will:

1. Ensure that all participants have had a chance to ask any questions that they have.
2. Refer participants for specific social supports that may contribute to better health and psychosocial outcomes for themselves and for their babies.
3. Ensure that all registration information is completed, including ANC number and facility, delivery facility, and facility where the infant will receive health care.

[TRAINER] will:

1. Ensure that the PFs have all the materials necessary for closing the group.
2. Track and monitor referrals by peer facilitators to ascertain what occur at health facility level when women are referred for health services.
3. Collect and review all group materials and reports, debrief with the PF on outstanding issues related to the group.

III. Procedures:
1. At the last group meeting, you will need about 15 minutes extra.
2. Review the attendance log and make sure that it is complete.
3. Thank all the participants for their time and their contributions to the EGPAF project.
4. Have each participant fill out the evaluation form.
5. After the forms have been completed and collected, have a discussion about what their favorite parts of the group sessions were, what they found to be most useful, and suggestions on how to improve.
6. Open a discussion on how the group may have changed the way they, or their family, have managed pregnancy, delivery and early infant care. Be sure to include this information in your report.
7. Encourage participants to refer their friends and neighbors to group sessions as appropriate (if the end of the project has been reached and there will be no additional groups, please inform the participants.)
8. Explain that this has been part of a research project and that the groups will likely be scaled up based on the project results.
9. Ensure that all participants have completed their information on their registration forms, especially the ANC number and facility, delivery facility and facility where the infant will receive care.
10. Complete the final report and return all forms related to this group to the supervisor.

IV. Resources
1. Form FCC10-2 Peer Group Final Report
2. Form FCC4-1 Peer Group Attendance register

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3. Form FCC3-1/2 Group registration forms
Peer Facilitators and Groups: SOP

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Introduction

I. Purpose of the SOPs

These Standard Operating Procedures (SOPs) provide detailed guidance to help ensure standardized implementation of the MNCH and Male Peer Groups under EGPAF. Both the MNCH and male peer groups are a series of four structured, peer facilitated sessions on topics related to MNCH, gender, and PMTCT to provide support to pregnant and breastfeeding women and their partners to achieve positive health outcomes for themselves and their families. These SOPs address recruitment, training, supportive supervision, assessment, and data collection activities for the peer groups. The SOPs are intended to be used along with other research and implementation resources to ensure that each country team executes the intervention according to set quality standards.

II. Target audience for these SOPs

These SOPs are intended to be used by EGPAF staff engaged in the implementation of the MNCH and the Male Peer Groups. Each country team should adapt the SOPs in line with national policies, team member roles, and existing country program implementation strategies.

Specifically, these SOPs target:

- Country Project Coordinators
- EGPAF Staff
- Strategic Information and Evaluation Officers
- Research Officers
- Data Collectors

A separate package of SOPs exists for peer facilitators. EGPAF staff should be knowledgeable of this package for effective implementation of the MNCH and the Male Peer Groups.

III. New Terminology

MNCH Peer Groups

The MNCH Peer Groups provide 10 – 15 (5-15 once the IRB approval is received) pregnant and breastfeeding women with an opportunity to share their experiences, share coping strategies, learn new knowledge, jointly problem-solve, and positively influence each other with support from a trained facilitator of the same gender.

Male Peer Groups

The Male Peer Groups provide 10 – 15 (5-15 once the IRB approval is received) men of reproductive age with an opportunity to share their experiences, learn new knowledge, jointly problem-solve, and positively influence each other on issues related to gender, fatherhood, and the man’s role in ensuring a safe motherhood experience to his partner’s birth preparedness with support from a trained facilitator of the same gender.

MNCH Peer Facilitators

MNCH peer facilitators are individuals who receive orientation and are equipped to lead structured discussions within small discussion groups. A facilitator should be a person with good communication and facilitation skills, discretion, recent experience with the
ANC/PMTCT context, influencing skills, and familiarity with health (especially MNCH issues in the community). Staff or volunteers from the R/DHMT, MOH, NGO, CBO, etc., can be equipped for this role.

**Male Peer Facilitators**

Male peer facilitators are individuals who receive orientation and are equipped to lead structured discussions within small discussion groups. A facilitator should be a person with good communication and facilitation skills, discretion, recent experience with the ANC/PMTCT context, influencing skills, and familiarity with health (especially MNCH issues in the community). Staff or volunteers from the R/DHMT, MOH, civil society, etc., can be equipped for this role.

**Informed Consent**

Informed consent is the process by which a project participant (peer facilitator or peer group member) voluntarily confirms willingness to participate in the meetings. This is after s/he has been told about and understood the purpose, risks and benefits of participating in the project. The decision to participate is documented in a written informed consent form, which the participant has signed and dated.
SOP C-0: Roles and Responsibilities of Training Staff

I. Purpose

The purpose of this SOP is to provide overall guidance on the roles and responsibilities of the EGPAF Staff and implementation staff when the MNCH and the Male Peer Groups are being conducted in the communities within this intervention arm.

II. Roles and Responsibilities of EGPAF Staff

1. Be knowledgeable of all SOPs related to the implementation of the MNCH and the Male Peer Groups.
2. Lead the recruitment and training of peer facilitators (PFs).
3. Ensure that adequate numbers of the PFs are selected and trained.
4. Ensure proper documentation of recruitment process.
5. Orient EGPAF program staff on the MNCH and Male Peer Group SOPs, implementation tools, training materials, and their expected roles and responsibilities.
6. Coordinate Peer Facilitator Trainings.
7. Ensure that the logistics are properly coordinated to support the work of the Peer Facilitators, and ensure that the PFs are provided with critical supplies to conduct their work, including EGPAF and MOH-approved IEC materials.
8. Ensure adherence to the EGPAF protocol by providing oversight and support to the implementation team.
9. In coordination with the M&E officer, ensure that the data collection tools are readily available and information is entered correctly and promptly.
10. EGPAF Staff should be assigned to supervise each PF and ensure that supportive supervision, mentorship, refresher trainings, and other activities are carried out to strengthen the capacity and performance of the PFs.
11. Ensure that participant feedback on training and supportive supervision processes is synthesized and fed into planning for future activities such as refresher trainings, and supportive supervision activities.
12. Take responsibility for the effective flow of communication and information between and among all stakeholders, including the EGPAF team, clinic staff, District Health Teams (DHT), District Health Management Teams (DHMT) members, peer facilitators, etc.
13. Respond to inquiries regarding the intervention as requested by the relevant country staff.
14. Ensure that country leadership and the EGPAF global team are aware of the bottlenecks, constraints, and challenges at community level, within the health system, and at project level.
15. Ensure informed consent is obtained from both peer facilitators and peer group members.
16. Delegate staff responsibilities (see III).

III. Roles and Responsibilities of Training Staff

2. Be knowledgeable of all SOPs related to the implementation of the MNCH and the Male Peer Groups.
3. Inform critical stakeholders, including clinic staff, CHWs, MNCH Focal Points, DHMTs, etc., about the purpose and intended outcomes of the MNCH and Male peer groups.
4. Support logistics for recruitment and initiation of the MNCH and Male peer groups.
5. Identify the different participant recruitment/entry points and ensure referrals of women and men who may benefit from the peer group activity.
6. Disseminate men’s and women’s group information.
7. Ensure that there are no conflicts in key messages of clinic counselling/education and key messages of MNCH or the male peer groups. Conflicts should be referred to EGPAF technical staff.
8. Ensure men, women, and children who are referred from peer group to clinic for specific services and support receive the services for which they are referred.
9. Conduct local awareness campaigns through posters, announcements in churches, announcements in community gatherings, etc. about the initiation of Male and MNCH peer groups in the community.
10. Support timely and continuous reporting and documentation of the MNCH and Male peer group activities.

IV. Roles and Responsibilities of Peer Facilitator Supervisor (or Training Staff)
1. Each PF will be assigned a supervisor/EGPAF Staff who will be responsible to:
   b. Plan and facilitate refresher trainings for PFs, based on their identified areas of need.
   c. Ensure that a mentorship and supportive supervision plan is in place for trained PFs.
   d. Participate in the mentorship and supportive supervision for trained PFs (including attending peer group meetings, providing refresher training, routine phone calls, courtesy calls, etc.).
   e. Plan and facilitate monthly support meetings for the PFs.
   f. Support PFs to engage in the other project interventions in their cluster.
   g. Maintain confidentiality of information shared by PFs.
   h. Ensure that all project documentation is properly completed, stored and submitted.

V. Procedures
The EGPAF staff assumes authority and accountability for the implementation of the PF interventions in country. The PF recruitment, training, and supervision processes should be adapted to each country’s local context; all adaptations are to be documented. The EGPAF Staff should be made aware of any adaptations and/or challenges during the PF intervention in a timely manner.
SOP C-1: Conducting the Training of Trainers for Peer Facilitator Trainers

I. Purpose

The purpose of the TOT workshop will be to provide the key staff who will implement the peer facilitators training, the supportive supervision and mentorship with the following:

a. Review roles and responsibilities of EGPAF project team in the process
b. Discuss adult/participatory learning methodology and the specific needs and challenges of working with the specified audience
c. Detailed review of the peer group process, including a thorough review of the SOPs
d. Detailed review of the workshop preparation process including how to prepare the data, preparing the site, etc.
e. Detailed review of the workshop materials and methodology
f. Detailed review of the mentorship materials and methodology
g. Discussion and review of tools, resources and activities to complement the training package
h. Plan the workshop logistics

II. Roles and Responsibilities

1. EGPAF Staff will ensure that:

a. The logistics for the TOT workshop are appropriately planned (venue is secured, the workshop materials and supplies are available, audio-visual aids, etc.).

b. Key resources for the TOT workshop are available.

c. Local staff who will participate in the adaptation workshop (the TOTs and any other technical advisors) are duly notified.

d. Key note speakers and presenters are duly notified of their responsibilities, and presentations are made available.

e. The Learning Needs Assessment results have been reviewed by the trainers.

III. Procedures

1. The planning team should develop and agree to a robust training schedule and logistics agenda for the TOT trainings, including:

a. Dates and times for conducting the TOT

b. Petty cash and procurement logistics

c. Supplies and materials
2. The planning team should designate one person to take a lead role in the trainings as a lead-facilitator.

3. Not less than three weeks prior to the specific workshop, the planning team should discuss/review with the co-facilitators:
   a. The detailed agenda for the five day workshop
   b. Designating the logistics focal point (who will work on venue finalization, transportation details, refreshments and meals, lodging, etc.)
   c. Designating the communications focal point (to work on notifying the relevant stakeholders and participants ahead of time)
   d. Assigning responsibilities for documentation and report writing
   e. Plans to invite guest speakers, key stakeholders, etc.
   f. The participant list for the TOT training

4. Prior to the workshop, workshop materials and supplies should be prepared, as listed in the workshop planning checklist.

5. Each participant should complete a needs assessment and return it to the EGPAF team at least a week before the TOT begins.

6. On opening day, the training team should observe the following:
   a. Ensure that every participant is fully registered.
   b. Start the workshop with introductions of all participants and facilitators.
   c. Develop ground rules for the workshop.

7. During the workshop, the training team should observe the following:
   a. Arrive at the workshop early enough to set up the room.
   b. Ensure that the room is organized in one of two sitting arrangements - a complete circle with no head or small tables that will fit six to eight participants.
   c. Assign a timekeeper and rule monitor for the day.
   d. Each TOT should follow the curriculum as closely as possible.
   e. A ‘parking lot’ should be generated during each session and revisited at the end of each session and day.
   f. Notes should be taken with particular attention paid to participants’ insights, shared experience, concerns, questions, action plans, and priorities

8. At the end of each day, the training team should allot thirty minutes to one hour to debrief the issues of the day, with a keen eye on:
   a. Content that participants have difficulty grasping or accepting
   b. Adjustments to the schedule
   c. Particularly successful or difficult sessions
d. Participants who might require further training and coaching on basic concepts

9. On the last day of the workshop, the training team should observe the following:
   a. Clear next steps from the EGPAF team are communicated to participants.
   b. Clear next steps from the participants are shared with each other and the EGPAF team.
   c. Participants agree to a monthly meeting schedule for the next quarter; this is in line with the planned supervisory and mentorship meetings.

10. The training team should schedule and hold a debriefing meeting no more than 24-48 hours after the workshop has been completed. The debriefing meeting should review:
   a. Participants who require intensive coaching on basic concepts beyond what their peers might require.
   b. Participants who require catch up sessions due to missed workshop or missed sessions.
   c. Successful innovations, ad libs, breakthrough moments, etc.

11. A detailed workshop report should be completed by the training team, using the workshop report template.
   a. Distribution list for the workshop report should be established and observed.
   b. The internal approvals process prior to distribution should be established and observed.
   c. The final workshop report should be available for internal distribution (within EGPAF) no later than 3 business days after the workshop.

V. Resources
  1. Form 2: Workshop attendance register
  2. Report RC1: TOT Template for workshop report
  3. Peer Facilitator Training TOT Package
I. Purpose
This SOP provides guidance on how peer facilitators will be approached and recruited in a process that is community-led, transparent, fair, and well-documented.

II. Roles and Responsibilities
[EGPAF Staff] will ensure that:

1. Recruitment is transparent, balanced, participatory, representative, fair, and follows the processes detailed in the procedures section of this document.
2. Adhering to the selection criteria specified for peer facilitators throughout the recruitment process.
3. Recruitment processes are observed, supported and supervised by the EGPAF staff.
4. The recruitment processes are well-documented.

III. Procedures
15. [EGPAF Staff] will notify the relevant offices and stakeholders of intent to commence recruitment at least one month before the recruitment process is scheduled to commence.
16. In each cluster, EGPAF staff will oversee peer facilitator selection via a referral process with clinics and trained community leaders.
17. The selection criteria for the peer facilitators is detailed below:
   a. The male and female cadres will be nominated by community members, health facility staff and community leadership.
   b. They should be dedicated and committed volunteers in health issues (Health workers can attest to this). They should be prepared to work as volunteers on this project.
   c. They should be able to read and write; having reached “O” level, (4 years of secondary. The peer facilitators should bring evidence of having reached “O” level (4 years of) to the EGPAF staff during the selection day.
   d. They should be between 25-45 years old (This can be discussed with the team and agree on the appropriate age).
   e. For MNCH Classes, the female facilitators should have attended ANC/PNC or having actively engaged in providing ANC support services in the recent past (5 years) in that community; delivered the last live birth in the health facility, has willingness to participate in the project, availability for the project period, positive views about the health facility and ANC/PNC, and good communication. The female peer facilitators should bring their ANC cards and baby cards for verification with the EGPAF team on the day of selection.
   f. Men with experience in group facilitation or teaching will be prioritized for consideration. Facilitators will be selected without regard to their HIV status.
   g. Both male and female peer facilitators should be people who have good public speaking, group facilitation, and listening skills. They should also have a passion for health issues.
   h. They should be people that are willing to reach out to everyone in the community regardless of social status, condition, religious or political affiliation (Health workers and community leaders can attest to this). These cadres should not be village health workers or other community-based cadres with many other duties in the community (Added after experience in Zimbabwe that these cadres had many responsibilities, which will make it difficult to meet the needs of this intervention).
i. They should be people that are local residents and have lived in the community for two or more years (Also debatable, will go with what the team will agree on).

18. All individuals who have been referred to be peer facilitators should be notified of the interview process, venue, date, and time.
19. There should be a standard interview for each nominee.
20. EGPAF staff should select peer facilitators based on selection criteria and interview marks after all interviews have been completed.

21. All corresponding forms must be accurately completed

IV. Resources
1. Form FC2-1 Peer Facilitator Recruitment Register
SOP C-3: Peer Facilitator Registration and Informed Consent

I. Purpose

All selected peer facilitators must complete the formal project registration and informed consent. The purpose of this SOP is to provide guidance on the peer facilitator registration and informed consent processes.

II. Roles and Responsibilities

EGPAF staff will ensure that:

1. Peer facilitators review a general overview of the intervention, as well as their anticipated roles and responsibilities.
2. Peer facilitator nominees should be registered, completed an informed consent form and are assigned a unique identification number before they participate in the intervention.
3. The peer facilitator contact and demographic information is thoroughly documented in the registration form.
4. Facilitators are appropriately informed of key dates and priorities.

III. Procedures

2. Selected peer facilitators should be informed of a range of dates and times when they can be formally briefed and consent to participate in the intervention.
3. [EGPAF Staff] will lead the consenting, registration and briefing. This process may take place individually or in a group. The briefing process should include:
   a. Overview and goals of the MNCH and/or the Male peer group intervention
   b. Intervention purpose
   c. Expectations of peer facilitators
   d. Procedures, logistics, and timelines
   e. Benefits he/she may gain for participation
   f. Participation is voluntary
4. Give him/her enough time to understand what this is about and what is being asked of him/her. Encourage him/her to ask questions and to stop you at any time if he/she is not clear or does not understand something. You may allow him/her to take the informed consent form home to discuss with him/her family if he/she wishes.
5. When the PF indicates that he/she is ready, take him/her to a quiet area, preferably out of sight of others so he/she can make his/her decision without undue influence.
   a. If he/she is willing to join the intervention, he/she should sign and date two copies of the informed consent form in ink. The PF will keep one copy of the signed and dated consent form and EGPAF staff will keep the original copy.
   b. Informed consent forms must be filed and stored securely throughout the collection process. The form must not be left lying around in the open, where people, children, and animals may accidentally or on purpose come upon it.
   c. On collection, the supervisor will check the informed consent forms to make sure that they are signed and dated properly.
   d. The supervisor will file the informed consent forms in a lockable file cabinet in her/his office, separate from other forms. The informed consent forms will need to be available for inspection by project monitors at any time.
informed consent form will be stored for three years after the end of the intervention. They should be available for audit after the end of the intervention.

6. Peer facilitators will be required to completely fill out the information requested on the registration form. [EGPAF Staff] will ensure that the participant recruitment forms are completed.

7. Have each PF fill out a Learning Needs Assessment survey and inform each one when and where their training will begin.

8. Ensure that each PF knows and meets their supervisor during this introductory session.

IV. Resources

1. Form FC3-1 Peer Facilitator Enrollment Log and ID List
2. Form FC3-2 Peer Facilitator Registration Form
3. Form FC3-3 Informed Consent Form [Must use IRB-approved Form for your country]
4. Form FC3-4 Learning Needs Assessment survey
SOP C-4: Conducting the Peer Facilitator Trainings

I. Purpose

Workshops will be organized to train peer facilitators so that they are competent enough to facilitate the peer groups. The purpose of this SOP is to provide detailed guidance to the EGPAF Staff in planning and conducting the PF trainings.

II. Roles and Responsibilities

3. EGPAF Staff will ensure that:
   a. Peer facilitators are oriented on their roles and responsibilities and are trained on the peer facilitator curriculum and SOPs.
   b. A detailed agenda and logistics plan for each day’s activities is discussed with the entire team.
   c. Adequate training materials and supplies are prepared for each training.
   d. Peer facilitators are informed about the logistics of the training.
   e. Peer facilitators are fully apprised of the purpose, intention, and objectives of the training.
   f. The registration forms are completely and accurately filled.

4. The trainers will ensure that:
   a. The manual for the peer facilitators is fully understood.
   b. All issues encountered during training are fully documented.
   c. All evaluations are completed as required.

III. Procedure

2. [EGPAF Staff] should develop a training schedule and logistics plan for rolling out the PF training, including:
   a. Dates and times for the workshops by cluster
   b. Transportation logistics
   c. Procurement logistics
   d. Training team and data collection assignments
   e. Communication plan to notify participants, district/regional/ward authorities of plans, and other stakeholders of workshop plans

3. The members of the training team (*comprised of two-three trainers and one data collector*) should be notified of their workshop assignments.

4. Before the specific workshop, the training team should hold a planning meeting to refine and finalize:
   a. Workshop agenda
   b. Designated logistics focal point, responsible for: Venue finalization, Transportation details, Supplies, Refreshments, etc.
   c. Communications focal point who will notifying the participants ahead of time
   d. Party responsible for documentation and report writing
5. Each peer facilitator should be notified of the workshop schedule by email, phone call, or SMS a minimum of two weeks before to the workshop.
   a. Peer Facilitators who confirm their participation on the stated dates should be noted.

6. EGPAF staff should ensure that prior to the workshop all workshop materials, supplies, and logistical details should be prepared, as listed in the workshop planning checklist.

7. On opening day, the training team should facilitate the following:
   a. Ensure that every participant completes the attendee register.
   b. Start the workshop with introductions of all participants.
   c. State ground rules for the workshop.

8. Throughout the workshop, the training team should observe the following:
   a. Arrive at the workshop early enough to set up the room.
   b. Ensure that the room is organized in one of two sitting arrangements; a complete circle with no head or small tables for six to eight participants.
   c. Assign a timekeeper and rule monitor for the day.
   d. Each trainer should follow the curriculum as closely as possible.
   e. A ‘parking lot’ should be generated during each session and revisited at the end of each session and day.
   f. Notes should be taken focusing on participants’ insights, shared experience, concerns, questions, action plans, and priorities.

9. At the end of each day, the training team should allot one hour to debrief the issues of the day, including:
   a. Content and sessions of difficulty
   b. Adjustments to the schedule
   c. Successful sessions
   d. Further training and coaching on concepts where needed

10. On the last day of the workshop, the training team should observe the following:
    a. Clear next steps from the EGPAF team are communicated to participants.
    b. Ensure that all participants receive their certificates and incentives.
    c. Notice that feedback from the participants will be shared with the EGPAF team.

11. A detailed training report should be completed by the training team using the workshop report template.
    a. Distribution list and internal approvals for the workshop report should be established and observed.
b. The workshop report draft should be available for internal distribution within EGPAF no later than **five** business days after the workshop.

c. The final workshop report should be available for external distribution no later than one month after the workshop.

12. Following training, PFs should be formally introduced to the community with the support of the EGPAF-trained Community Leaders. Introductions should include:

   a. Village heads, inner council
   b. Rural Health Motivators (RHM)
   c. Community Health Workers (CHW) and/or Village Health Workers (VHWs)
   d. Clinic staff, especially those that will serve as recruitment/entry points to the peer groups
   e. Other key community stakeholders

IV. Resources

1. Form 2: Workshop attendance register
2. Form FC4-1 Peer Facilitator Training Workshop Evaluation
4. Peer Facilitator training curriculum
5. Ministry of Health IEC Materials
6. EGPAF Peer Groups SOPs
SOP C-5: Piloting the Peer Group Curriculum

I. Purpose
After training, the Peer Facilitators will pilot the group curriculum to ensure that they are able to meet intervention objectives with the target audience in each country.

The purpose of this SOP is to provide guidance on the piloting process of the Peer Group sessions by the Peer Facilitators.

II. Roles and Responsibilities

2. EGPAF Staff will ensure that:
   a. The logistics for the pilot are appropriately planned
   b. Peer facilitators have completed the Peer Facilitators Training
   c. Feedback from participants is utilized to refine the training
   d. The sections of the curriculum that will be piloted for are faithfully executed
   e. All issues encountered during the pilot are fully documented
   f. All participant evaluations are completed as required
   g. All notes for peer feedback are completed as required

III. Procedures

1. EGPAF staff will assist the EGPAF team to select a site for the pilot based on a thorough consideration of the logistical and financial implications. Ideally, the site/community where the pilot will take place should be within EGPAF sites. However, this will not be feasible in all cases.

2. Selection of the pilot cluster should be negotiated in close coordination with the cognizant Regional/District authorities and implementing partners (as appropriate), and take into consideration, the relevant protocols.

3. Each Peer Facilitator must conduct at least one session in a supervised pilot before conducting groups on their own.

   Selecting participants

4. Working with the main EGPAF project, [EGPAF staff] should identify and recruit for participation in this pilot, a group of women and men likely to have similar demographic factors, influence, and educational status as specified in the peer group selection criteria.

5. No more than eight to twelve participants should be selected to take part in each pilot, in order to ensure that the participants have the opportunity to provide extensive feedback.
6. EGPAF staff will ensure that all logistics, including venue, participant list and contact information, refreshments and meals, workshop materials, participant forms, transportation refunds and participant compensation are adequately catered for.

7. EGPAF staff will ensure that all participants receive formal communication on the purpose and intents of the pilot exercise.

Conducting the pilot exercise

8. The peer facilitators will lead the pilot effort in pairs or in triplets, and at least one member of the project management team (ideally EGPAF Staff) must be present.

9. Each peer facilitator should lead one session during the pilot and observe their colleagues for the additional segments.

10. The EGPAF staff will take detailed notes on the following:

   a. The facilitator’s mastery of the content and approach
   b. The facilitator’s skilful facilitation of the participants
   c. Appropriateness of the sequence of the material in the curriculum
   d. Key questions asked by participants, including those that indicate resistance, difficulty grasping the material, limited time allotted in schedule, etc.
   e. Contentious or controversial issues
   f. Profile of participants who grasp and/or embrace material
   g. Profile of participants who struggle with and/or reject material

11. After completion of each session of the pilot, the EGPAF staff should ensure that:

   b. Key questions have been documented.
   c. The PFs have the opportunity to probe the issues that are lacking clarity and resolution.
   d. The PF’s knowledge is probed through skilfully guided conversational tactics.
   e. The points requiring clarity and resolution are carefully documented.

12. After completion of the entire pilot, each participant should be required to complete the pilot evaluation. The EGPAF staff should thoroughly review each evaluation for completion.

13. After completion of the pilot, the trainers should be given adequate time to compile brief notes on their peer-feedback.

14. The entire pilot team should generate a brief report with details of the session and key action items, utilizing the workshop report outline.

IV. Resources

1. Form 2: Workshop Attendance Register
2. Report RC5: Pilot Workshop Report Template
SOP C-6: Recruitment of Peer Group Members and Assignment to Groups

I. Purpose

The purpose of the SOP is to provide guidance for EGPAF staff on the recruitment of peer group members.

II. Roles and Responsibilities

EGPAF Staff will ensure that:

1. All stakeholders are notified that all men of reproductive age, women, pregnant, and breastfeeding mothers should be informed of the activity and referred to the PFs for membership in the MNCH and Male Peer Groups.
2. Create and distribute localized recruitment bullets to help PFs remember what to say during recruitment.
3. Forms to refer women and men to the peer groups have been adapted and shared with all stakeholders.
4. Logistics for relaying forms and reporting any critical incidents to [EGPAF Staff] are clarified at community level.
5. Participants are grouped with group identifiers and lists are provided to each peer facilitator.

III. Procedures:

1. Meet with stakeholders and inform them that recruitment of MNCH and Male peer group participants has commenced.
2. Create a strategy and clear enrollment timeline to recruit group members and assign roles and responsibilities among EGPAF staff.
3. Draft recruitment bullets that should be utilized by peer facilitators. These bullets must be shared with PFs in advance of the start of recruitment.
4. Recruit participants from the community before deadline for enrollment.
5. Women will be recruited during community days, through general referrals from ANC clinics, by community leaders, through community health workers (CHWs) / VHTs, from local water points, and churches.
   a. Women to be recruited should meet the following criteria:
      1. Reproductive age (16 and above)
      2. Pregnant, non-pregnant women or breastfeeding
6. Men will be recruited from numerous entry points, including: at community days, through general referrals from VCT points, referrals from STI clinics, referrals from HIV care and treatment services, by community leaders, through community health workers/VHTs, RHMs, and churches.
   a. Men to be recruited should meet the following criteria:
      1. Reproductive age (18 and above)
      2. Residing in the community
7. The Group Members sign up forms should be collated and sorted so that participants can be assigned to PFs and to each group using the Peer Group Consent and Registration Meeting List.
8. EGPAF staff will assign individuals to each group based on factors such as village, peer facilitator location, age, gestational age (for women), marital status, and other locally-determined criteria. Use each group number only once!

9. Assign group numbers as follows:
   a. Use the country prefix and the numbers can begin from 10 to 100 and above. See the examples below:
      - 01-100

10. Groups will comprise 10-15 participants (5-10; the minimum number of group participants is 5.

11. EGPAF staff should ensure that logistical preparation for all group meetings and proper member communication occurs.

IV. Resources
1. FCC1-1 Group Members Sign Up Form
2. FCC1-3 Peer Group Consent and Registration Meeting Participant List
SOP C-7: Supervising the Informed Consent and Registration for Peer Group Participants

I. Purpose
This SOP will provide guidance to EGPAF staff on how to complete the participant registration process.

II. Roles and responsibilities

EGPAF Staff will ensure that:
1. Peer Facilitators understand the instructions to complete the registration forms and process.
2. Each peer group participant is and assign a unique group ID number
3. The participant demographic information is thoroughly documented.
4. Participants are appropriately informed of key dates and priorities.
5. Peer Facilitators receive close supervision for the first few cycles of participant registration.
6. A registration form is completed for each participant.

III. Procedures

1. EGPAF Staff supervise the recruitment of participants, ensure that group capacities are met, and that informed consent is properly obtained prior to group meetings commencing.
2. EGPAF Staff will coordinate and supervise registration process. Staff must ensure that the PFs understand how to complete the registration forms and how to assign unique registration number. Initial registrations should be supervised.
3. Upon collection, EGPAF staff must review all forms to ensure they are accurately completed.

IV. Resources

1. Form FCC1-3 Registration Meeting Participant List
SOP C-8: Supportive Supervision of Peer Group Sessions

I. Purpose

The purpose of this SOP is to detail guidance for supportive supervision of the planning and execution of the peer group sessions. Supportive supervision is a critical element for ensuring quality implementation of the peer groups by the peer facilitators.

II. Roles and Responsibilities

EGPAF staff will:

1. Ensure that all Peer Facilitators are trained on the curriculum and SOPs before starting the group meetings.
2. Ensure that a detailed agenda and logistics plan for the groups is agreed upon and discussed with the entire team, including peer facilitators; that adequate materials and supplies are prepared for the group discussion; and that participants are informed about the logistics of the group discussion.
3. Attend the first module/session of peer group meetings in the first round of implementation by each PF. Thereafter, will attempt to attend as many first modules/sessions of peer group meetings as possible.
4. Ensure all concerns with the progress of group meetings are addressed, documented, and properly referred to the correct venue.
5. Oversee that each PF report is written in the PF Session Notebook immediately on completion of the group and available within three days of their group session.

III. Procedures

1. Assist with logistics such as consenting, registration, ID assignment, assessment and/or sign-in documentation.
2. Supervise the first module of peer group meetings. Active supervision will include:
   a. Observe each PF’s facilitation skills, taking note of tone, technical accuracy, ability to respond to questions, ability to identify questions beyond their scope, handling of difficult participants, and use of participatory techniques.
   b. Step in during cases where there is marked departure from the material or an inability to convey material clearly - without undermining the authority of the PF.
   c. Assist in identifying any cases where participants might benefit from further one-on-one discussion or from a referral.
   d. If invited, participate in one-on-one discussions between PF and participant.
   e. After observed module, host a one-on-one meeting with PF to reflect on performance, share observations, and identify areas of improvement.
   f. Guide PFs on completing their documentation during and after the observed session.
   g. Complete a Supportive Supervision checklist for each session observed.

IV. Resources

1. Form FC9-1 Supportive Supervision checklist
2. Peer Facilitator SOP package
3. Implementation materials including manuals and flip charts
SOP C-9: Providing On-going Mentorship to Peer Facilitators

I. Purpose

The purpose of this SOP is to detail guidance for planning and providing on-going mentorship to the EGPAF peer facilitators.

II. Roles and Responsibilities

[EGPAF Staff] will:

1. Develop a mentorship and supportive supervision plan to take effect immediately after the PF trainings.
2. Maintain and update the mentorship and supervision plans, forms, and registers for all PFs.
3. Oversee EGPAF staff conducting ongoing mentorship PFs and ensure clear communication.
4. Monitor trends related to drop-offs between participants attending first modules/sessions of peer group meetings and returning for next sessions.

III. Procedures

1. Organize debriefings with the PFs after the initial training to identify areas of challenge. Take note of areas each PF has requested additional mentorship or has struggled.
2. Develop a tailored mentorship and supportive supervision plan for each PF.
3. Establish open communication:
   a. PFs should reach out to the EGPAF Staff anytime they have any issues or concerns.
   b. PFs should have the EGPAF Staff’s mobile phone number.
   c. PFs may be provided with cell phone credit so that they may call when they need to.
4. Supervise the first module of peer group meetings and thereafter as many as possible.
5. Update mentorship and supportive supervision plans and provide individualized support for PFs.
6. Conduct on-going mentorship meetings with each PF every two weeks for the first month and monthly thereafter. Meetings with the PFs should occur in small groups from the same or neighboring community and must occur locally.
   a. Suggested meeting topics include:
      i. Attendance of participants.
      ii. Speed at which material is being covered (what module number a PF is on, and whether all the material from the previous modules was covered as laid out).
      iii. Report on general conversation dynamics, conversation flow, participant’s participation, participant’s grasp of concepts, etc.
      iv. Any challenges at hand and possible solutions.
      v. Pair PFs for understudy as needed.
vi. Remind PF of Attendance Register safe keeping.
   b. One-on-one support should be provided as needed.
7. At each meeting, collect Attendance Register with enrollment numbers and update PF contact information if it has changed.
8. At a minimum, each PF will receive one additional supportive supervision visit to peer group meeting within the first quarter.
9. Using the monthly Facilitator Tally Form, monitor and document the trends related to drop-offs between in participants attending first modules/sessions of peer group meetings and participants returning for next sessions.
10. Under the supervisor tally boxes at the end:
   a. # of Groups Starting Session #1: Count the number of groups formed and assigned a number
   b. # of Participants Session #1: Count the number of participants that complete the first KAPB survey and attend the first group session
   c. # of Participants completing Final KAPB: Count the number of participants that completed the 4 group sessions (including one on one sessions) and completed the final KAPB lite survey

IV. Resources
1. Form FC10-1 Mentorship Plan/ Technical Support Menu
2. Form FC10-2 Monthly Tally Form (For Supervisors)
3. Peer facilitator SOP
SOP C-10: Conducting the Quarterly Peer Facilitators’ Meeting

I. Purpose

This SOP provides guidance for the quarterly meeting of Peer Facilitators with EGPAF staff.

II. Roles and Responsibilities

The EGPAF staff and PF supervisors/ will set the agenda and facilitate the meeting. A staff member should be assigned to take notes and write the report of the meeting.

The PFs will bring their Peer Facilitator Session Notebooks and Monthly Tally Forms.

III. Procedures

1. The supervisors of the PF and EGPAF staff will conduct a quarterly meeting of the PFs. This should be in at least groups of 5 PFs, but can include all according to the country needs. The meetings may be held more often in the beginning of the project as decided by the EGPAF staff.

2. The Quarterly PF meeting can replace the monthly meeting with the supervisor as long as the individual PF is doing well. It is up to the discretion of the supervisor to schedule as many meetings with individual PFs as they feel are necessary to provide the needed support.
   a. Each PF should give a brief summary of their groups, highlighting any challenges and successes.
   b. The facilitator will note common themes for further discussion.
   c. It is essential that the PFs have time to ask any questions and discuss problems with group procedures or content, and to define any additional support needs they may have.
   d. The EGPAF staff should reiterate key responsibilities of the PFs regarding confidentiality and record keeping.
   e. The facilitator should bring the group to consensus on any next steps or follow up and ensure that these items are reported back at the next meeting.

IV. Resources

SOP C-11 Tracking Participants Referred for Health and Social Services

I. Purpose

Peer Facilitators will be expected to refer participants who have not completed critical health visits, or who express specific social supports. The purpose of these SOPs is to provide guidance on supervising this referral process and its documentation.

II. Roles and Responsibilities

[EGPAF Staff] will:

1. Create service directory and distribute to PFs.
3. Follow up to ensure that peer facilitators are not attempting to handle or address issues for which they are not equipped. Emphasize that technical issues will be addressed by professional.
4. Track and monitor referrals by peer facilitators to ascertain what occur at health facility level when women are referred for health services.

III. Procedures

1. Some participants may indicate that they have not completed important health visits and milestones in their clinical care, which may place themselves and/or their babies at risk. If such a case occurs, the PFs must be trained to refer these participants to the nearest health facility. Ensure that this is well documented, so that follow up can occur at higher levels.
   a. The CHW, VHW or RHM will refer participants to groups. It should be stressed that this relationship should be reciprocated when the need arises.
2. Collect copies of peer facilitator referrals and follow up with the referral facility.
3. Record and track the number of referrals to facilities and what care is given if any. Please document in monthly and quarterly reports where applicable.

IV. Resources

1. FCC5-1: Community-Facility Referral Form
2. Service directory (created in country)
SOP C-12: Closing Peer Groups

I. Purpose

This SOP will guide the procedures for ending each of the groups after the four sessions have been completed.

II. Roles and responsibilities:
1. The PF will close the group and prepare a summary report for the supervisor.
2. The supervisor will discuss with each group with the PF to understand any issues and highlight successes and will collect all data pertaining to the group.

III. Procedures
1. At their regular meeting, the supervisor will review all the registration forms from the group to ensure that all necessary information has been gathered. If not, the PF will be requested to contact the individual participant to obtain the missing information.
2. The PF will turn in the Group Logbook, the report from the final session, a final report and the complete participant evaluations.
3. The forms and the reports will be returned to the EGPAF office where the information will be entered into the database.

IV. Resources
1. F CC 10-1 Peer Facilitator Group Final Report
2. F CC 10-2 Peer Group Participant Evaluation
I. Purpose

The purpose of this SOP is to set out the procedure for documenting and reporting on Peer Facilitators or participants who drop out of the MNCH and the Male Peer Group or provide notification that they no longer intend to participate in the group.

Definition of Termination from the Intervention:

Termination from the intervention refers to participants who are no longer participating or who wish to withdraw from the intervention. Termination can be informal or formal. Informal termination is when PFs or participants no longer attend the support groups; they may or may not give a reason for their lack of attendance. Formal termination is when the participant gives notice that he/she wishes to withdraw from the intervention. Informal termination is where a participant stops attending at least two support group sessions and appears to have no intent to return.

If many PFs or participants terminate from the intervention, whether formally or informally, this may mean that their participation is harming them in some way. It may also affect the intervention and could cause the project to potentially not meet its goals or purpose. It is important therefore to be aware of the number of terminations of PFs and from the MNCH and Male peer groups, and review the reasons for the termination so that necessary actions can be taken to prevent participant harm and ensure that the MNCH or Male peer group activity will not be negatively affected.

II. Roles and responsibilities

Each [EGPAF Staff] will:

1. Routinely gather reports from PFs regarding participants who are no longer participating in the peer group activities.
2. Monitor the intervention withdrawal trends for PFs and participants by each PF and each group.
3. Review the reasons for intervention termination.
4. Discuss how to minimize participant harms that cause intervention termination.
5. Discuss how to minimize social and logistical barriers that cause intervention termination.
6. Ensure that intervention termination forms are completed.
7. Store completed intervention termination files in a secure, locked cabinet.

III. Procedures

1. Formal Termination
   a. If a PF informs you that s/he wishes to withdraw from the project, you should document this on the form “Withdrawal from the intervention”. You should complete the following: Write date the request was made, in the space provided.
      i. PF name and ID number; and reason for termination.
      ii. If you are able to find out the reason(s) why the PF has terminated from the group, you should write this in the space provided. This may give information on how the
project is being perceived and if there are any potentially negative consequences of the project.

b. If a group participant withdraws before completing all four sessions:
   i. Collect any withdrawal forms from the PF.
   ii. Place the form in a file folder in your bag, or in a place where unauthorized people will not have access to it.
   iii. EGPAF Staff will give the form to the EGPAF Community Focal Person.
   iv. In the office, the withdrawal form information will be entered into the project database and the form will be kept in a lockable file cabinet separate from the informed consent forms.
   v. The forms must be kept for a minimum of three years after the end of the intervention.

IV. Resources
   1. Form 5 Intervention Termination Form
   2. Form FC3-1 Peer Facilitator Enrollment and ID List
Peer Group Forms

The following materials are available to support implementation:

- Men’s Peer Group Peer Facilitators’ Training manual
- Women’s Peer Group Peer Facilitators’ Training manual
- Men’s Peer Group Flipchart
- Women’s Peer Group Flipchart

**Peer Group Management Forms:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>RC-1</td>
<td>Template for TOT Workshop Report</td>
</tr>
<tr>
<td>FC2-1</td>
<td>Peer Facilitator Recruitment Register</td>
</tr>
<tr>
<td>FC3-1</td>
<td>Peer Facilitator Enrolment Log and ID List</td>
</tr>
<tr>
<td>FC3-2</td>
<td>Peer Facilitator Registration Form</td>
</tr>
<tr>
<td>FC3-4</td>
<td>Peer Facilitator Learning Needs Survey</td>
</tr>
<tr>
<td>FC4-1</td>
<td>Peer Facilitator Training Attendance Register</td>
</tr>
<tr>
<td>FC4-2</td>
<td>Peer Facilitator Training Evaluation</td>
</tr>
<tr>
<td>RC4</td>
<td>Peer Facilitator Training Workshop Report Template</td>
</tr>
<tr>
<td>RC5</td>
<td>Peer Facilitator Pilot Workshop Report Template</td>
</tr>
<tr>
<td>FC9-1</td>
<td>Supportive Supervision Checklist</td>
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<tr>
<td>FC10-1</td>
<td>Mentorship Plan</td>
</tr>
<tr>
<td>FC10-2</td>
<td>Peer Group Monthly Tally Form</td>
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<tr>
<td>RC11</td>
<td>Quarterly Peer Facilitators Meeting Report Template</td>
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<td>Form 5</td>
<td>Study Termination Form</td>
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**Peer Facilitator Forms:**

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<tbody>
<tr>
<td>FCC1-1</td>
<td>Peer Group Sign-up Form</td>
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<tr>
<td>FCC1-2</td>
<td>Peer Group Meeting Planning Checklist</td>
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<tr>
<td>FCC1-3</td>
<td>Peer Group Registration Meeting: Participant List</td>
</tr>
<tr>
<td>FCC3-1</td>
<td>Peer Group Attendance Register</td>
</tr>
<tr>
<td>FCC3-2</td>
<td>Male Participant Registration Form</td>
</tr>
<tr>
<td>FCC3-3</td>
<td>Female Participant Registration Form</td>
</tr>
<tr>
<td>FCC4-1</td>
<td>Facilitator Session Report</td>
</tr>
<tr>
<td>FCC5-1</td>
<td>Community and Health Referral From EGPAF Peer Groups</td>
</tr>
<tr>
<td>FCC10-1</td>
<td>Peer Group Final Report</td>
</tr>
<tr>
<td>FCC10-2</td>
<td>Participant Evaluation (Peer Group)</td>
</tr>
</tbody>
</table>
Deliberations – Summary of key content highlighting participant contributions during following segments

- Overview of the project
- Review of the formative assessment and survey results
- Overview of the conceptual approach of the intervention and workshop curriculum
- High-level walk through of the curriculum content
- In-depth review of the curriculum content

Key Recommendations – Summary of necessary edits to ensure

- Cultural relevance (local sayings, cultural practices, traditional institutions, etc)
- Appropriateness of the language
- Health system, political structures, and social organization is accurately reflected
- Responsiveness to community priorities (from formative research)
- Appropriate pacing of the material
- Appropriate scope of the material
- Appropriate balance between practice, brainstorming and lectures
- Relevance of handouts

Next Steps

- Follow up items
- Persons responsible
- Module session preparations
- Timelines

List of participants

- Names
- Position/Title
- Institution
### FC2-1: Peer Facilitator Recruitment Register

<table>
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<tr>
<th>Community ID: __ __</th>
<th>Community Name:</th>
<th>EGPAF Team representative:</th>
<th>Date Completed (dd/mm/yyyy): __ __ <strong>/</strong>/ __ __ __</th>
</tr>
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#### Recruitment Committee Members:

<table>
<thead>
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<th>Title:</th>
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#### Last Name | First Name | Sex F/M | Good group facilitation, public speaking, listening skills (Y/N) | Female: ANC, delivered at facility (Y/N) | Male: Positive gender attitude (Y/N) | Dedicated/committed to community health issues (Y/N) | 4 years of Secondary school (Y/N) | Available and staying throughout project (Y/N) | Selected (Y/N) | Date notified (dd/mm/yy) |
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# Form FC3-1 Peer Facilitator Enrolment Log and ID List

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<thead>
<tr>
<th>Staff Name</th>
<th>Community Name</th>
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<tbody>
<tr>
<td>Date</td>
<td>Staff ID</td>
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<table>
<thead>
<tr>
<th>Peer Facilitator Last Name</th>
<th>Peer Facilitator First Name</th>
<th>Registration Date (dd/mm/yy)</th>
<th>Consent Date (dd/mm/yy)</th>
<th>Copy of consent to PF</th>
<th>PF ID Given (Community no: PF 01-99)</th>
<th>Date of PF Training</th>
<th>Supervisor Name</th>
<th>Date Terminated (dd/mm/yy)</th>
<th>Reason (Refused, End of Project, Withdrew, or list other)</th>
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<tbody>
<tr>
<td>__Yes</td>
<td>__PF</td>
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**Form FC3-2: Peer Facilitator Registration Form**

<table>
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<th>Date: __ __ - ___ ___ - 20 ___ ____</th>
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<tbody>
<tr>
<td>Day       Month       Year</td>
</tr>
<tr>
<td>Community Name:</td>
</tr>
<tr>
<td>Staff ID</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Peer Facilitator Identifier: _____ _____ PF _____ _____</td>
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<tr>
<td>Community Number       PF Number</td>
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**DEMOGRAPHIC INFORMATION**

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<td></td>
<td>1 Yes</td>
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<td>DATE SIGNED:</td>
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<th>Last Name</th>
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<tr>
<th>First Name</th>
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<th>Age (in completed years)</th>
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<tr>
<th>Address (please write directions or map on back of page)</th>
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<tr>
<th>Village of residence</th>
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<tr>
<th>Mobile Phone/s</th>
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**BACKGROUND AND INSTITUTIONAL INFORMATION**

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<thead>
<tr>
<th>Title</th>
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<tbody>
<tr>
<td>Mr 1</td>
</tr>
<tr>
<td>Mrs 3</td>
</tr>
<tr>
<td>Miss 2</td>
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<td>Ms 4</td>
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<tr>
<td>Dr 5</td>
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<td>Honourable 6</td>
</tr>
<tr>
<td>Chief 8</td>
</tr>
<tr>
<td>Other (Specify) 99</td>
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<tr>
<th>Position/Background</th>
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<tr>
<td>Role</td>
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</tr>
<tr>
<td>Traditional Leader</td>
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<td>Political Leader/Elected representative</td>
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<tr>
<td>Religious Leader</td>
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<tr>
<td>Civil Society Leader</td>
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<tr>
<td>Civil Servant</td>
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<tr>
<td>Women’s Leader</td>
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<tr>
<td>Youth Representative</td>
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<tr>
<td>Media Representative</td>
</tr>
<tr>
<td>Business/Private Sector Leader</td>
</tr>
<tr>
<td>Community Health Worker</td>
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<tr>
<td>Peer Educator</td>
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<tr>
<td>No position</td>
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<tr>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

Peer Facilitator Signature: ________________________________
Form FC3-4: Peer Facilitator Learning Needs Survey

Thank you for registering for the Peer Facilitator’s Training Workshop. We are excited about sharing the EGPAF methodology and curriculum for conducting the peer groups. These groups involve health literacy and peer education. There will be a training workshop to prepare you to conduct these groups and document them in the right way.

To help us design the workshop so that it best meets your needs, please respond to the following questions:

1. Your Name:

2. Indicate if you have attended trainings, workshops, or technical updates on any of the following in the past (select all that apply):

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Behavior change communications</td>
<td></td>
</tr>
<tr>
<td>b. Sexual prevention of HIV and AIDS</td>
<td></td>
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<tr>
<td>c. Peer education/peer learning methodologies</td>
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<tr>
<td>d. Prevention of mother to child transmission of HIV/AIDS</td>
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<td>e. Adult learning methodologies</td>
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<tr>
<td>f. Monitoring and evaluation</td>
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<td>g. Conflict resolution and negotiation</td>
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<td>h. Advocacy and communications</td>
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</table>

3. Have you conducted discussion groups for adult lay audiences in the past?  
   _____Yes  _____No

4. Do you have any supervision, project planning, and/or project management experience?  
   _____Yes  _____No

5. Which specific issues would you like the training workshop to focus on?

6. What group discussion skills would you like the training workshop to help you gain?
**FC4-1 PEER FACILITATOR TRAINING ATTENDANCE REGISTER**

[Can also use country-specific forms if all information is collected]  
*Adapted Form 2: Workshop Attendance Register*

<table>
<thead>
<tr>
<th>Peer Facilitator</th>
<th>Participant initials (daily)</th>
<th>Check if terminated or withdrawn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community No: PF ID</td>
<td>Last Name</td>
<td>First Name</td>
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</tr>
</tbody>
</table>

Staff ID (lead facilitator): __________________  Staff ID (co-facilitator): __________________  Staff ID (co-facilitator): __________________

Venue: __________________________  Date (dd/mm/yy): __________________________

Community Name: [Fill in names of all Community from which participants have been selected] ________________________________________________________________
# FORM FC4-2 PEER FACILITATOR TRAINING EVALUATION

<table>
<thead>
<tr>
<th>District/Region Name:</th>
<th>Date: ___ ___ - ___ ___ - ___ ___</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Day – Month – Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Name &amp; Number:</th>
<th>Venue:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>61. Was there enough space for participants to be comfortable?</td>
<td>Yes ☐ (1) No ☐ (2)</td>
</tr>
<tr>
<td>62. How was the food at this venue?</td>
<td>Very good ☐ (1) OK ☐ (2) Poor ☐ (3)</td>
</tr>
<tr>
<td>63. How would you rate the project team’s organization?</td>
<td>Very organized ☐ (1) Organized ☐ (2) Disorganized ☐ (3)</td>
</tr>
<tr>
<td>64. How well did the facilitators do?</td>
<td>Very good ☐ (1) Good ☐ (2) Poor ☐ (3)</td>
</tr>
<tr>
<td>65. How was the quality of the participant materials?</td>
<td>Very good ☐ (1) Good ☐ (2) Poor ☐ (3)</td>
</tr>
<tr>
<td>66. How would you rate the number of the topics covered in this workshop</td>
<td>Just the right amount ☐ (1) A little too much material ☐ (2) Not enough material ☐ (3)</td>
</tr>
<tr>
<td>67. Was there enough time to cover each session?</td>
<td>Yes ☐ (1) No ☐ (2)</td>
</tr>
<tr>
<td>68. Was there enough time for participant interactions and sharing?</td>
<td>Yes ☐ (1) No ☐ (2)</td>
</tr>
<tr>
<td>69. Was there enough time for questions and answers?</td>
<td>Yes ☐ (1) No ☐ (2)</td>
</tr>
</tbody>
</table>

**Suggestions**

70. What parts of facilitating peer groups do you feel most prepared to do?

71. What parts of facilitating peer groups do you least ready for?

72. Anything to add or change about the workshop?

73. What is one thing you liked about this workshop?

74. Do you have any other thoughts or suggestions?
Deliberations – Summary of key content highlighting participant contributions during following segments

- Overview of the project
- Review of the formative assessment and survey results
- Overview of the conceptual approach of the intervention and workshop curriculum
- High-level walk through of the curriculum content
- In-depth review of the curriculum content

Key Recommendations – Summary of necessary edits to ensure

- Cultural relevance (local sayings, cultural practices, traditional institutions, etc.)
- Appropriateness of the language
- Health system, political structures, and social organization is accurately reflected
- Responsiveness to community priorities (from formative research)
- Appropriate pacing of the material
- Appropriate scope of the material
- Appropriate balance between practice, brainstorming and lectures
- Relevance of handouts

Next Steps

- Follow up items
- Persons responsible
- Module session preparations
- Timelines

List of participants

- Names
- Position/Title
- Institution
Report RC5: Peer Facilitator Pilot Workshop Report Template

Country, authors, venue, and dates
Workshop Agenda (attach)
Workshop Facilitators (list):

1. Summary of key content highlighting participant contributions during following segments
   - Was the material easy to deliver and follow?
   - Was the language appropriate to the target group?
   - Organization of the material and the sessions – did the material flow in a logical way?
     Would any pieces need to be moved to another section, was there too much repetition?
   - Technical content - how easy was it to follow and understand? Was there too much/too little detail? Were there any difficult issues to facilitate? If so, how best can these be improved?
   - How were cultural content, myths and misconceptions addressed?
   - Relevance of these issues in addressing the objectives of the peer facilitator intervention
   - Appropriate balance between practice, brainstorming and lectures

2. Things that went well and sessions that participants liked the most
3. What was new or surprising to the participants?
4. What were the lessons learned from reviewing and facilitating these sessions?
5. Any other comments from the pilot

List of participants (attach)
- Names
- Position/Title
- Institution

FC9-1 Supportive Supervision Checklist

<table>
<thead>
<tr>
<th>Community Name:</th>
<th>Date:</th>
</tr>
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<tbody>
<tr>
<td>Peer Facilitator ID:</td>
<td>PF</td>
</tr>
<tr>
<td>Name of Peer Group Facilitator:</td>
<td></td>
</tr>
<tr>
<td>Session Number:</td>
<td>Name of Supervisor:</td>
</tr>
<tr>
<td>1 2 3 4</td>
<td>(circle)</td>
</tr>
</tbody>
</table>

SKILL #1: Manage Process

<table>
<thead>
<tr>
<th>1=Satisfactory</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=Not Satisfactory</td>
<td></td>
</tr>
</tbody>
</table>

Participants sit in circle
Facilitator(s) introduce themselves to the group
Facilitator(s) clearly explain the day’s theme
Facilitator(s) ask questions that generate participation
Facilitator(s) motivate the quiet women/men to participate

Score SKILL #1: Skilled Management of Process (Sum items above):
<table>
<thead>
<tr>
<th>SKILL #2: Use of Counselling Skills</th>
<th>1=Satisfactory</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the Facilitator(s) appropriately apply:</td>
<td>0=Not Satisfactory</td>
<td></td>
</tr>
<tr>
<td>Listening and Learning skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building Confidence and Giving Support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SCORE SKILL #2: Use of Counselling Skills (Sum items above):

<table>
<thead>
<tr>
<th>SKILL #3: Facilitate Discussion</th>
<th>1=Satisfactory</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Facilitator(s):</td>
<td>0=Not Satisfactory</td>
<td></td>
</tr>
<tr>
<td>Encourage mothers/fathers to share their own experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draw out ways that other participants have solved problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guide discussion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SCORE SKILL #3: Facilitate Discussion (Sum items above):

<table>
<thead>
<tr>
<th>SKILL #4: Manage Content &amp; Materials</th>
<th>1=Satisfactory</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Facilitator(s):</td>
<td>0=Not Satisfactory</td>
<td></td>
</tr>
<tr>
<td>Ensure that ‘correct/good’ behaviours/beliefs and attitudes are emphasized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correct any misinformation, as necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to refer technical issues and note any unanswered questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use Training Aids, as appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SCORE SKILL #4: Manage Content & Materials (Sum items above):
## SKILL #5: Motivate Continued Participation

<table>
<thead>
<tr>
<th>1=Satisfactory</th>
<th>0=Not Satisfactory</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The facilitator(s) thanks the participants for attending and invites them to attend the next session (place, date and theme)</td>
<td></td>
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<tr>
<td>The facilitator(s) ask participants to discuss what they have learnt with a member of their household and report back</td>
<td></td>
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<tr>
<td>The facilitator(s) ask participants to talk to others about what they are learning</td>
<td></td>
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</tbody>
</table>

**(Sum items above):**

## SKILL #6: Monitor attendance

<table>
<thead>
<tr>
<th>1=Satisfactory</th>
<th>0=Not Satisfactory</th>
<th>Comments</th>
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<tbody>
<tr>
<td>The facilitator(s) complete and submit support group attendance form</td>
<td></td>
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</table>

**(Sum items above):**

### Total Score out of eighteen (18) points

Facilitator questions and difficulties, along with action:

**Supervisor Feedback to Facilitator**
# FC10-1 Mentorship Plan

<table>
<thead>
<tr>
<th>Team Member ID:</th>
<th>Month/Year:</th>
<th>Community Number</th>
</tr>
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<tbody>
<tr>
<td>Peer Facilitator Number:</td>
<td>PF</td>
<td>PF Name:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Issues/Types of support Required</th>
<th>Support planned</th>
<th>Date Scheduled</th>
<th>Date Completed</th>
<th>PF Initials Signature</th>
<th>EGPAF Staff Initials Signature</th>
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</tbody>
</table>
## FC10-2: Peer Group Monthly Tally Form (for supervisors)

<table>
<thead>
<tr>
<th>Supervisor Name:</th>
<th>Supervisor Number:</th>
<th>Community Name:</th>
<th>Community Number:</th>
<th>Date (dd/mm/yyyy)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Group ID</th>
<th>Peer Facilitator Name</th>
<th>Peer Facilitator Number</th>
<th>Session # held (Reg 0, 1-4)</th>
<th>This Month’s Meeting Date</th>
<th># Participants (including one-on-one)</th>
<th>Closed: # Participants completing Final KAPB Lite</th>
</tr>
</thead>
<tbody>
<tr>
<td>PG</td>
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</tbody>
</table>

### SUPERVISOR TALLY:

<table>
<thead>
<tr>
<th>Number of Active Groups</th>
<th>Groups Starting Session #1</th>
<th># Participants Session #1</th>
<th>Groups Finishing Session #4</th>
<th># Participants Session #4</th>
<th># Completing Final KAPB</th>
</tr>
</thead>
</table>

430
Report RC11: Quarterly Peer Facilitators’ Meeting Report Template

Cover page (Community/Community name, venue, dates)

Meeting Facilitators
Table of contents

Meeting Objectives

Meeting Agenda

Opening Remarks

Deliberations

Breakthrough opportunities

Summary of progress
  - Summary of implementation reports from Peer Facilitators
  - Summary of critique and feedback from peers
Summary of presentation, critique and/or feedback from meeting facilitators and/or guest speakers
  - Challenges reported by Peer Facilitators

Next Steps
  - Recommendations for the EGPAF staff
  - Recommendations for the Peer Facilitators

Follow up items and timelines
  - Priorities for refresher trainings
  - Mentorship needs
  - Agenda for the next forum meeting

List of participants
Form 5 Study Termination Form

<table>
<thead>
<tr>
<th>Staff Name:</th>
<th>Staff ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Date completed (dd/mm/yy):

Community Name and ID:

Person withdrawing:
- [ ] Peer Facilitator – PF
- [ ] Group Participant

Date began with EGPAF:

<table>
<thead>
<tr>
<th>Reason for withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Applicable to trained facilitators ONLY

I attest that I am withdrawing participation from this study on good terms. All financial or in-kind obligations promised by the project have been honored. I am owed no financial or in-kind remuneration for the voluntary work I have done on behalf of my community.

Date: _____________________ Signature: ___________________________

Submitted by:

Date: _____________________ Signature: ___________________________

Signed by in-country PI:

Date: _____________________ Signature: ___________________________
Peer Facilitator Forms
Form FCC1-1 Peer Group Sign Up Form

<table>
<thead>
<tr>
<th>Community Name</th>
<th>Community Number</th>
<th>Date (dd/mm/yyyy): <strong>/</strong>/<strong><strong>/</strong></strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex: F/M</th>
<th>Is Participant or Partner Pregnant? Y/N</th>
<th>If yes, expected date of delivery (if known)</th>
<th>Gestational age (Months)</th>
<th>Phone Number</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
Adapt and use as you like – this form is to help the Peer Facilitator and is not turned in or entered into the database.

<table>
<thead>
<tr>
<th>Date Due</th>
<th>Item</th>
<th>Tick</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Venue selected</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date and time selected</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EGPAF staff notified of location and date</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peer group member notified of location and date</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transport arranged if applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refreshment arranged</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>EGPAF forms printed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Learning materials printed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
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<td></td>
</tr>
</tbody>
</table>
## Form FCC1-3 Peer Group Registration Meeting: Participant List

<table>
<thead>
<tr>
<th>Date</th>
<th>Community ID</th>
<th>Supervisor Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Facilitator Name</td>
<td>Supervisor ID</td>
<td></td>
</tr>
<tr>
<td>Peer Facilitator Name</td>
<td>PF</td>
<td>Group Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Participant Enrolled?</th>
<th>If not enrolled, Reason</th>
<th>Copy to participant</th>
<th>Registration complete</th>
<th>KAPB Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
</tr>
<tr>
<td>02</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
</tr>
<tr>
<td>03</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
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<tr>
<td>04</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
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<td>Yes  No</td>
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<td>Yes  No</td>
<td>Yes  No</td>
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<td>06</td>
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<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
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<td>Yes  No</td>
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<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
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</tbody>
</table>
## FCC3-1 Peer Group Attendance Register

<table>
<thead>
<tr>
<th>PF Name:</th>
<th>Peer Facilitator ID</th>
<th>PF</th>
<th>Peer Group Number</th>
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</table>

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>Participant Name</th>
<th>Registration DATE:</th>
<th>Session #1 DATE:</th>
<th>One on One DATE:</th>
<th>Session #2 DATE:</th>
<th>One on One DATE:</th>
<th>Session #3 DATE:</th>
<th>One on One DATE:</th>
<th>Session #4 DATE:</th>
<th>One on One DATE:</th>
<th>FINAL KAPB Y/N</th>
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<tbody>
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</tbody>
</table>
**Project EGPAF Participant Register for Men’s Groups**

<table>
<thead>
<tr>
<th>Community Name/Number</th>
<th>ID NUMBER ____ ____ ____ ____ – ____ ____ ____</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group Number</td>
</tr>
<tr>
<td>Date</td>
<td>Form filled in by ____________________________</td>
</tr>
<tr>
<td></td>
<td>Print name</td>
</tr>
</tbody>
</table>

### DEMOGRAPHIC INFORMATION

<table>
<thead>
<tr>
<th>Informed consent signed</th>
<th>0 No (do not continue until informed consent is signed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Yes</td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>1 Single 2 Married 3 Divorced 4 Widowed 5 Living with Partner</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Village of residence</td>
<td></td>
</tr>
<tr>
<td>Mobile Phone</td>
<td>(if you have more than one phone number, write them all)</td>
</tr>
</tbody>
</table>

### FAMILY INFORMATION

<table>
<thead>
<tr>
<th>Number of children</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Is partner currently pregnant</td>
<td>0 No 1 Yes</td>
</tr>
<tr>
<td>If yes, is partner enrolled in women’s group</td>
<td>0 No 1 Yes</td>
</tr>
</tbody>
</table>

### GROUP RECRUITMENT INFORMATION

<table>
<thead>
<tr>
<th>How recruited for group</th>
<th>1 Community Day 2 Wife/partner 3 Health Facility 4 Other community member</th>
</tr>
</thead>
<tbody>
<tr>
<td>If community day, participated in dialogue?</td>
<td>0 No 1 Yes</td>
</tr>
</tbody>
</table>
**Form FCC3-3: Female Participant Registration Form**

*Participant Register for Women’s Groups*

---

<table>
<thead>
<tr>
<th>Community Name:</th>
<th>ID NUMBER __ __ __ __ – __ __</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group Number</td>
</tr>
<tr>
<td></td>
<td>Participant Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date: ___ ___ - ___ ___ - ___ ___</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Day – Month – Year</em></td>
</tr>
</tbody>
</table>

Form filled in by ____________________________________________

Signature___________________________________________

---

**DEMOGRAPHIC INFORMATION**

Informed consent signed 1 Yes 2 No * (do not continue until informed consent is signed) *

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Single</td>
</tr>
<tr>
<td>2 Married</td>
</tr>
<tr>
<td>3 Divorced</td>
</tr>
<tr>
<td>4 Widowed</td>
</tr>
<tr>
<td>5 Living with Partner</td>
</tr>
</tbody>
</table>

Age

Address (please write directions or map on back of page)

Village of residence

Mobile Phone (if you have more than one phone number, write them all)

---

**CLINIC INFORMATION**

ANC clinic name

ANC number

Expected date of delivery

Intended delivery facility

---

**AFTER DELIVERY**

Delivery date

Delivery facility  Infant clinic number

---

**FAMILY INFORMATION**

Number of children

Is partner enrolled in a men’s group 0 No 1 Yes

---

**GROUP RECRUITMENT INFORMATION**

How recruited for group 1 Community Day 2 Husband/partner
<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Other community member</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Community Day, participated in dialogue?</td>
<td>0 No</td>
</tr>
</tbody>
</table>
Form FCC4-1: Facilitator Session Report

Note: PFs can use a blank notebook with this page as a guide on what to write, or the EGPAF team may choose to print special booklets of this form.

<table>
<thead>
<tr>
<th>PF Name:</th>
<th>Peer Group Number</th>
<th>PG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Facilitator ID</td>
<td>PF</td>
<td>DATE</td>
</tr>
<tr>
<td>Session # (1-4)</td>
<td>Number of Participants (0-15)</td>
<td>Length of session (in minutes):</td>
</tr>
<tr>
<td>How would you rate this session</td>
<td>1. Easy, everything went well</td>
<td>2. Fine, but a few difficult issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Difficult, did not go well</td>
</tr>
<tr>
<td>What topic generated the most interest?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What did the participants have to say about it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questions or issues raised by participants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topics that required the most time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe any issues that were difficult for participants to understand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Areas that PF would like assistance in addressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggestions to improve this session</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FCC5-1: Community and Health Referral Form EGPAF Peer Groups

[Note: Countries should use their national referral forms; Countries may adapt this to fit their needs]

<table>
<thead>
<tr>
<th>Peer Facilitator making this referral</th>
<th>Contact number for Peer Facilitator</th>
<th>Peer Group Participant Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PG</td>
</tr>
</tbody>
</table>

**Peer Facilitator Number**

<table>
<thead>
<tr>
<th>PF</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Health Facility Name</th>
</tr>
</thead>
</table>

Date (dd/mm/yyyy):

___/___/___

2. **Client Name:**

_________________________________________  ______________________________

First                                      Last

3. **Date of Birth:** _____________________  2. **Sex:**    [ ] Male   [ ] Female

4. **Services needed:**

_____________________________________________________________________________

5. **Name of health facility referred to:**

_____________________________________________________________________________

Group Participant Number  PG ___  ____  ____-  ____  ____

**REFERRAL FACILITY STAFF:**

*PLEASE COMPLETE THIS PART OF THE FORM, TEAR OFF AND RETURN TO PROJECT EGPAF STAFF*

With questions or concerns, please contact: EGPAF at _____________

Name of health facility: _______________________________

Date client arrived at facility for services: (dd/mm/yyyy): ___/___/___
Form FCC10-1: Peer Group Final Report

<table>
<thead>
<tr>
<th>PF Name:</th>
<th>Peer Group Number</th>
<th>PG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Facilitator ID</td>
<td>PF</td>
<td>DATE</td>
</tr>
</tbody>
</table>

(Complete individual session report first, then complete this report, which should summarize all sessions for this group)

Date of last session

<table>
<thead>
<tr>
<th>1. I was able to get participants to speak openly</th>
<th>4. The materials given out were helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Strongly Agree</td>
<td>□ 1. Strongly Agree</td>
</tr>
<tr>
<td>□ 2. Agree</td>
<td>□ 2. Agree</td>
</tr>
<tr>
<td>□ 3. Disagree</td>
<td>□ 3. Disagree</td>
</tr>
<tr>
<td>□ 4. Strongly Disagree</td>
<td>□ 4. Strongly Disagree</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. My supervisor provided good support to me for this group</th>
<th>5. The participants finished with a good understanding of the materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Strongly Agree</td>
<td>□ 1. Strongly Agree</td>
</tr>
<tr>
<td>□ 2. Agree</td>
<td>□ 2. Agree</td>
</tr>
<tr>
<td>□ 3. Disagree</td>
<td>□ 3. Disagree</td>
</tr>
<tr>
<td>□ 4. Strongly Disagree</td>
<td>□ 4. Strongly Disagree</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. I understood the content of the sessions</th>
<th>6. The sessions had enough time</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Strongly Agree</td>
<td>□ 1. Strongly Agree</td>
</tr>
<tr>
<td>□ 2. Agree</td>
<td>□ 2. Agree</td>
</tr>
<tr>
<td>□ 3. Disagree</td>
<td>□ 3. Disagree</td>
</tr>
<tr>
<td>□ 4. Strongly Disagree</td>
<td>□ 4. Strongly Disagree</td>
</tr>
</tbody>
</table>
7. What did you like most about this group? What did you learn?

8. What could be improved?

9. Please share other comments you might have about your experience at this group
## Form FCC10-2 Participant Evaluation (Peer Group)

<table>
<thead>
<tr>
<th>Group Number</th>
<th>PG</th>
<th>Date: ____ ____ - ____ ____ - ____ ____</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><em>Day – Month – Year</em></td>
</tr>
</tbody>
</table>

Participant number of respondent (optional):

1. I was encouraged to participate openly
   - [ ] 1. Strongly Agree
   - [ ] 2. Agree
   - [ ] 3. Disagree
   - [ ] 4. Strongly Disagree

2. The topics that were covered were important to me
   - [ ] 1. Strongly Agree
   - [ ] 2. Agree
   - [ ] 3. Disagree
   - [ ] 4. Strongly Disagree

3. I understood the content of the sessions
   - [ ] 1. Strongly Agree
   - [ ] 2. Agree
   - [ ] 3. Disagree
   - [ ] 4. Strongly Disagree

4. The materials given out were helpful
   - [ ] 1. Strongly Agree
   - [ ] 2. Agree
   - [ ] 3. Disagree
   - [ ] 4. Strongly Disagree

5. The facilitator had a good understanding of the issues in the sessions
   - [ ] 1. Strongly Agree
   - [ ] 2. Agree
   - [ ] 3. Disagree
   - [ ] 4. Strongly Disagree

6. The sessions had enough time
   - [ ] 1. Strongly Agree
   - [ ] 2. Agree
   - [ ] 3. Disagree
   - [ ] 4. Strongly Disagree

7. What did you like most about this group? What did you learn?
8. What could be improved?

9. Please share other comments you might have about your experience at this group.