



Community-Based Approach to Support Community Listening, Advocacy, and Action Planning During Public Health Emergencies Manual





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For more information please contact:

Feven T. Mekuria

Senior Advisor, Community Health Systems

feventassaw.mekuria@care.org

Allison Prather

Senior Technical Advisor, Public Health Emergencies

allison.prather@care.org

Health Equity and Rights Team

CARE USA

151 Ellis St. NE, Atlanta, GA 30303

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Welcome

This manual provides guidance for holding listening sessions with communities and healthcare workers during a public health emergency and describes how to use this information to support a community-based emergency response. This approach is designed to support meaningful community participation that influences the emergency response.

This manual draws on the experience of CARE's use of these tools during the Ebola and COVID-19 public health emergencies in the Democratic Republic of the Congo (DRC). The tools and guidance included in this manual incorporate feedback solicited from community members, healthcare workers, health officials, and CARE staff through an evaluation, as well as the expertise of CARE's global technical advisors who have years of experience implementing similar approaches in different contexts. This manual will show you how to use tools that support community listening through group discussions, group exercises, and facilitated conversations between community members and healthcare workers. The manual also provides tools for advocacy and action planning. Not all tools in this manual need to be used in every health emergency. This manual provides several tools, and it is up to you to decide which tools are best suited for your project's objective, context, and target audience. We encourage you to adapt the tools to your context and your goals.

Target Audience for this Manual

This manual has been designed for public health officials, non-profit organizations, and other groups in the community who want to help community voices be heard during public health emergencies. This manual is designed for individuals and groups to assist them in incorporating communities into their response to public health emergencies.

Note: "Facilitator" is used throughout this manual and refers to the person who is leading an activity.

1

Introduction

1

1.1 What is CARE's Approach to Support Community Listening, Advocacy, and Action Planning During Public Health Emergencies?

In this manual, we explain how CARE combined two community-based approaches that it has used successfully in non-emergency health programs in various countries around the world since 2002: 1) Social Analysis and Action (SAA) and 2) the Community Score Card (CSC).

These tools seek to:

1. Guide discussions on community beliefs, attitudes, practices, and power dynamics that influence behaviors related to the response
2. Identify key issues impacting health service delivery and use during the response
3. Support the development of community-led advocacy and action plans to help address issues raised.

Essential to this approach is the engagement of various groups and individuals, including community members, healthcare workers, government authorities, non-profit organizations, and others that can influence decisions to help improve the emergency response to meet the needs of everyone affected by the emergency.

Social Analysis and Action (SAA)

The first CARE approach used in this manual is the Social Analysis and Action approach. The first part, “social analysis,” means to have a group conversation where participants look at (“analysis”) how people talk and treat each other (“social”) during a health emergency. For this part, facilitators will lead a conversation about what happens during a health emergency, not just about how people talk with and treat each other, but also about what rules and attitudes (“norms”) guide how people act. By having these conversations (“social analyses”), the group can become aware of some ways that norms may be unfair or harmful to people. These discussions can help communities to discuss and determine if there are norms that negatively impact their health and move communities towards new norms that empower and uplift communities.

The “action” part of “social analysis and action” happens after the discussions. The ideas from the discussions will help the group to take actions that will help reduce the negative effects of the health emergency on the community or help bring the emergency to an end.

The process has three key parts:

- Reflection and dialogue: Thinking about how the health emergency is affecting the community and talking about it together
- Exploration of alternative views and challenging norms that are harmful: Talking about ways that the community may disagree, and discussing what is behind those disagreements
- Moving towards action to shift norms for improved health outcomes: Talking about things the community can do together to improve everyone's lives during the health emergency, and what the community can do to help end the emergency

See CARE's
Global SAA
Manual
available online
([click here](#)).

Tools from this approach have been adapted to help identify and explore community beliefs, norms, practices, and power dynamics that influence behaviors that relate to public health emergency response.

Community Score Card (CSC)

Community Score Card, or CSC, is CARE's approach to engaging communities in creating accountability for high-quality and accessible health services. This means that individuals are responsible for ensuring that everyone can access the healthcare services that they want and need. The goal of the approach is to:

- Build the confidence of community members to help make their wants and needs known to authority figures in the community
- Build relationships between community members and authority figures in the community
- Create spaces where community members can voice their opinions to authority figures in a way that moves everyone towards improved access to health services

See CARE's
Global CSC
Manual
available online
([click here](#)).

Tools from this approach have been adapted to help healthcare workers and community members build trust and work together to improve the delivery and use of health services during a public health emergency.

1.2 Do No Harm

Whenever you do work with the community, even if it is meant to help everyone, it is very important to think carefully about whether you might cause someone harm, even without meaning to. In the past, there have been times when people working in communities have caused harm because they did not think carefully ahead of time about things that might happen as a result of their actions. For example:

- Setting up meetings in places far from where people live - this may put certain people in danger due to the long travel and it might be expensive.
- Providing gifts or money to people without providing some form of protection - this may cause these people to be harmed by family or other people who want the gifts or money.
- Using leaders or influential people to identify participants and deliver health services - this might lead to certain people being included and certain people being excluded
- Discussing “sensitive” topics, like gender or who has authority or family planning, without engaging the entire community - this might lead to harassment or violence against participants
- Promoting or encouraging women and girls to access health services like family planning without addressing barriers - this can cause backlash from their families and communities against the girls

When using this manual, it is important to think about how you might unintentionally harm the community or individuals in the community in the public health emergency response. Use the sections below to consider ways to prevent harm.

Reflect and Discussion with Communities



- Before holding discussions with community members, project staff should think about how to adapt this manual's tools and process to the context and culture of the public health emergency. This includes making sure that all activities and tools are translated into local languages, so they are easier to understand.
- Facilitators should remind participants that sharing personal information is not required and that personal information should not be shared. No one should be forced to participate.
- It is possible that participants will talk about gender-based violence during some activities. If a participant talks about something that happened to them, the facilitator should be ready to listen and provide a referral for support services.

Exploration of Alternatives



- When discussing beliefs, attitudes, and practices that are harmful to health, facilitators can encourage participants to come up with actions to address the issues they have identified. To support planning, facilitators may ask what, who, how, and when about an action. They can also ask participants about who in the community may support or oppose the planned actions.
- If community members choose actions that might cause harm - to either participants themselves or other community members - facilitators should alert project managers and work with the group participants to identify appropriate alternative actions to prevent harm.

Action Planning



- Change should be led by members of the community and should be based on local knowledge and local leadership.
- Anyone who is using this approach should be familiar with the political situation, degree of press freedom, and government approach to human rights. If there is opposition to this approach, it is important to know what the consequences may be.

2

2

Planning and Preparation

2.1. Mapping Out Emergency Responders

Before using this approach, you should try to learn about who else is engaged in the emergency response. This mapping exercise aims to understand existing work that supports community engagement: who is doing what and where? The activity supports coordination with other emergency responders and will help you determine the design and scope of your project so that it adds to other strategies to support community listening. If there are coordination groups dedicated to supporting health risk communication and community engagement as part of the emergency response, you should consider participating. Engaging in these groups will help to improve coordination of the emergency response. It will also improve the overall impact of the response.

Mapping out emergency responders should be done with the support of local leaders, health leaders, government officials, non-profit organizations, including women and youth-led groups, and other emergency responders.

This exercise is only the beginning of an ongoing relationship with other organizations and individuals responding to the emergency. It is recommended to engage authorities and other emergency responders when planning to use this approach and agree on the roles that each individual/group will play to support the different steps of the approach. These include design, implementation, review of findings, advocacy, and action planning. Engaging authorities and other emergency responders from the start will likely lead to building accountability for everyone engaging in the emergency response.

2.2 Adapting This Approach for Your Context

A “design workshop” is a good starting point for planning the community listening, advocacy, and action planning activities. In the design workshop, the team leading this work will be introduced to the community-based tools used in this approach. The implementing organization and partners can strategize how they will support data collection, analysis, and sharing, assign responsibilities, and create a timeline for their work.

Participants include members of the project team who will oversee the implementation of the approach, including key partners such as government partners, non-profit organizations, and community leaders.

Goals:

1. Introduce the project staff and their roles.
2. Plan with stakeholders to ensure that project staff and partners agree on the goals, activities, and expected outcomes of the project.
3. Decide on roles and responsibilities of each individual/group supporting the approach, including project staff, government partners, non-profit organizations, community leaders, and other emergency responders.
4. Review existing data from your context to better understand how to select and adapt tools from this manual.

In the DRC, CARE invited partners to the design workshop, including Ministry of Health officials and members of the Health Area Improvement Planning Team.

3

Implementation



3.1 Community Listening Tools: Understanding Beliefs, Attitudes, Practices, and How Authority Influences Health Behaviors in an Emergency

Overview of the Tools

These tools are designed to support community listening by using group discussions and group exercises to learn more about the emergency context. This context includes community beliefs, attitudes, practices, and authority that influence behaviors related to the emergency.

Findings from these tools can help you make changes to your project that better meet the needs of all people who are affected by the emergency. The tools support community listening and amplify community voices to influence the response. Tools included in this section are:

- **Social mapping:** A tool used with community members to identify important places, groups, and resources in the community; who owns, controls, and accesses these resources; and how gender, social, and power norms affect ownership, control, and access. During a health emergency, this tool can provide information on who has and who does not have access to resources that can support disease prevention practices and other health behaviors that support the emergency response.
- **Focus groups:**
 - **With community members:** Focus groups with community members can provide insight into beliefs, attitudes, practices, and concerns held by community members. These focus groups can also help you to understand the relationship between healthcare workers and communities.
 - **With healthcare workers:** Focus groups with healthcare workers can provide insight into beliefs, attitudes, and practices within this group. Healthcare workers can also share their beliefs about the impact of the emergency on health services. You may also learn about the community's access to and use of health services during the emergency.
- **Influencer analysis:** A tool used with community members to identify who holds power and the extent to which these individuals/groups support or oppose parts of the emergency response.

If you are unfamiliar or uncomfortable with facilitating focus groups, this resource from FHI 360 may be helpful ([click here](#)).

Planning

The planning process for implementing these tools starts with a meeting of everyone involved in leading the discussions with community members and healthcare workers, supporting the data analysis, and sharing the findings. These parties include organizational staff, the Ministry of Health, and local health authorities and leaders. This meeting aims to:

- Clarify roles and responsibilities for different individuals/groups involved
- Discuss and define goals, process, and expected results
- Discuss who will be included in the focus groups and request that your staff be introduced to leaders in the community

Try to talk to a diverse group of community members so you hear more perspectives. CARE recommends separate discussions with different groups within the community, so each group feels supported. These different groups may include women, youth, people with disabilities and other groups depending on your context. You can request that community health workers or other health/community leaders help explain the discussion goals to community members. After the planning meeting, you should visit your project location to recruit participants for discussions and to select locations where you can have the focus groups. You

should choose participants for different activities with the help of local health and government authorities.



- Individual streets are identified by certain categories - such as streets where the rich or those in power live and the streets where poor individuals live.
5. Use symbols or pictures to identify each institution and public place on the map. Add a drawing to the map that shows the symbols/pictures and their name so everyone can understand what is on the map.
 6. After the mapping is done, use the next half hour and the following questions to lead a group discussion. In the emergency context, you can also ask if and how the situation has changed during the emergency.
 - Are there any institutions and resources that are accessed only by men or women? Why? Why not?
 - Are there any institutions or resources that only certain age groups or caste/classes can access?
 - Is there any space where neither men, women, boys, nor girls have access? Why?
 - Are there any groups that specifically target women and girls?
 - Who controls different institutions? Who controls access to public resources, such as those offered by the government?
 - Do these institutions and resources benefit women and men equally? Why? Why not?
 - Which are the places where people do not go often and why do they not go there?
 - Are there specific people who are not allowed to access some places? Is it dangerous for them to go there? Why?
 - Are there specific areas where poorer members of the community reside? Are these groups treated differently? If yes, how so?
 - What kinds of services are you missing in terms of quality and availability? How has this changed during the emergency? Who is most impacted?
 7. After the discussion, ask participants to reflect on what they have learned from the exercise.
 8. Encourage participants to share what issues were discussed and what they learned with their family and friends who were not present if they feel comfortable doing so. Remind them that personal information should be kept within the group. Finally, ask participants to think about how to deal with some of the issues discussed during the session. These reflections should be captured and shared with emergency responders to support advocacy and action planning.
 9. Document the session by taking photos of each group's work and compiling notes taken by facilitators throughout the session. *Annex A* contains a template for notetaking for this exercise.

Notes for Facilitators

Social mapping allows the community to reflect on access and use of resources and services and the ability of people to safely move about in the community. This exercise results in data that can help with designing and improving effective emergency responses. For example, you could learn that vaccines are being provided at a location that most people cannot access because it is too far. Or maybe vaccines are only being provided at times when most individuals are at work.

If the participants are broken into groups by gender and age, the discussions can focus on a social map from a man's perspective, a woman's perspective, a young person's perspective, how these are different, and why they are different. Depending on your context, you may choose other groups to consider.

7. Move groups to their designated spots and give them 3-4 flipchart pages and a marker. There should be at least one facilitator per group who can help when asked. Otherwise, the facilitator should take notes without participating in the discussion, other than asking each question.
8. Each group should have about an hour to work through the questions below.
9. After each group works for about an hour, they can come together for presentations and discussion. This part of the activity may take up to 1.5 hours. If you are planning to record the session, tell this to the participants. If they would like to participate without their voice being recorded, they can alert you, and you can turn off the recording and write down what they said.
10. The leader of each group should present their discussion for 10 minutes. Then, the entire group can discuss their presentation for 15 minutes. The facilitators should take notes during the presentation and discussion.
11. After the presentations, the facilitator should summarize the discussion back to participants, question by question, and ask them to say if anything was recorded incorrectly and how to fix the summary.
12. After the discussion, facilitators should collect all the flip charts.

Notes for Facilitators

If the participants are separated into groups by gender and age, the discussions can focus on a man's perspective, a woman's perspective, a young person's perspective, how these are different, and why they are different.

There should be at least one facilitator for each group and one lead facilitator for the big group.

If you decide to use the activities in Section 3.3 of this manual, the focus group facilitators can ask for volunteers to participate. In these activities, community members and healthcare workers will discuss issues that impact health service delivery and use during the emergency. The information from focus groups will be the base for these discussions. You should try to include representation from each of the groups (example: men, women, and young people).

In *Annex B*, there is a template for notetaking.

Categories and Example Questions

- Beliefs and practices to prevent the spread of the disease (if the health emergency is an outbreak). Questions in this section explore what people have heard about the emergency, what people believe about the emergency, how important people believe it is to prevent the spread of the disease linked to the emergency, which recommended behaviors are easier or harder and why, and what could help improve the use of recommended practices. Examples include:
 - What have you heard about the emergency? What do you think of the situation?
 - Which recommended behaviors are easy to practice? Why?
 - Which behaviors are not easy to practice? Why?
 - What do you think would help improve practices to prevent the spread of the outbreak in this community?
 - *If a vaccine is available and accessible, you may explore beliefs about the acceptability of this vaccine. Examples include:
 - What have you heard about the vaccine?
 - How likely are you to get vaccinated once a vaccine becomes available?
 - What would influence your decision?
- Beliefs and practices related to use of health services. These questions explore how people view health facilities during the health emergency, if there are new or more barriers to accessing services, and if there is fear associated with visiting health facilities. Examples include:
 - How do people talk about health facilities during health emergencies?



- What does your community think about people who go to health centers during the emergency?
- What do you think is working well that helps people use health services during the emergency?
- What is not working well that stops people from using health services during the emergency?
- Additional beliefs and social relationships related to power and decision-making during the emergency. These questions explore other traditions in the community that impact people's decision making, such as traditions that conflict with following recommended to prevent disease spread or go to the health center. You can also explore other beliefs that are important for the response, such as trusted sources of information.
 - Is there a common tradition in your community that is impacting people's health during this health emergency? For example, a belief that contributes to the spread of the disease or impacts the use of health services.
 - Who follows this norm and how?
 - How do people make decisions about when to seek healthcare in your community?
 - Which sources of health information do you trust in the community? Which sources do you trust less? Why?



3. Focus Group Discussions with Healthcare Workers

Healthcare workers can be recruited during the initial visits to your project location. During this time, you can also determine the location, date, and time of the focus groups. There are some sample questions below that can be adapted to your context for use with healthcare workers.

In the DRC, CARE and Ministry of Health officials held two healthcare worker focus groups per health area. There were 100 total participants (10 medical and 10 non-medical staff, in separate groups, per health area).

Purpose of the tool

To learn more about healthcare workers' beliefs, attitudes, and practices related to the emergency and how health service delivery and use have been impacted.

Time required

2-3 hours

Participants

Participants can include any individuals that work in healthcare. They can be clinicians who provide medical services such as doctors, nurses, and community healthcare workers and non-clinicians who do not provide medical services but support health services, such as administrative staff working in health facilities.

Materials needed and other preparation required

Flip chart papers, markers, or sketch pens of different colors, index cards or sticky notes, and a pen and paper for the facilitators

Steps

The focus group with healthcare workers follows the same steps as the one with community members (see the previous section). For this group, there are suggested topics and questions below.

In the DRC, example issues identified in the focus groups include:

1. Lack of trust in health services leading to fear of going to health centers.
2. Rumors and wrong information related to COVID-19.
3. Lack of trust and stigma against foreigners.

Notes for Facilitators

If the participants are separated into groups of medical and non-medical health staff, the discussions can focus on their perspectives of healthcare service delivery, how these are different, what these are differences, and why.

There should be at least one facilitator for each group and one lead facilitator.

In *Annex B*, there is a suggested template for notetaking during these focus groups.

11. Document the session by taking photos of each group's work and combining notes taken by facilitators.

Notes for Facilitators

Engagement with influencers should be unique and strategic. Some practices and beliefs to be challenged are essential for the influencers to keep their power and challenging such traditions will be strongly resisted by such influencers. Other influencers will be important allies in challenging harmful practices.

Consider using a digital tool to collect data for all activities/meetings to save paper and make it easier to share data.



6. Documentation

Information gathered in this section should be documented and shared with partners to raise awareness of key issues related to the health emergency and any recommendations to improve the response.

In *Annex C*, there is a suggested framework for documenting and reporting on the results of these tools.





3.2 Community Listening Tools: Facilitating Discussions with Community Members and Healthcare Workers to Prioritize Issues Impacting Health Service Delivery and Use in an Emergency

Overview of the Tools

This section uses tools and methods adapted from CARE’s Community Score Card approach to identify, prioritize, and address issues impacting health service delivery and use in a health emergency.

Tools and steps included in this section are:

- *Prioritization of issues impacting health service delivery and use*: this tool includes a simple table to document issues impacting health services from the perspective of community members and healthcare workers. The table also includes a space to rank issues to remember which are most important to address and the reasons supporting this choice.
- *Indicator development*: this additional table guides the process of clustering issues into groups that can be described as an indicator to “score” and developing a “scoring matrix”.
- *Indicator scoring*: this step includes meeting with community member and healthcare worker groups to “score” the indicators to decide which issues are most important to address and why.

1. Prioritization of Issues Impacting Health Service Delivery and Use

This first step is to create a score card for the community and for healthcare workers to assist in prioritizing issues. This will create a way to track health service delivery improvements. This process involves reviewing findings from previous focus groups on issues related to health service delivery and use, building on these issues, and ranking issues to identify the most important ones.

Time required

1-1.5 hours

Participants

Separate focus groups in each project location with community members and healthcare workers. For community members, have separate discussions for each group, including women, men, and youth.

Materials needed and other preparation required

- Flip chart paper and markers or pens
- Each group should have at least two facilitators - one to lead the discussion and one to take notes.

Steps

1. Invite a group of community members and healthcare workers to discuss issues impacting health service delivery and use. For community members, separate the group into smaller groups for women, men, and youth. Each group should first meet separately to share ideas about key issues impacting service delivery and use. Facilitators should present findings on issues impacting health services from the previous focus groups. Building on these findings, facilitators can then ask the following questions to invite ideas from each group. The questions can be asked to learn how the project can help health facilities continue to provide essential health services that community members can continue to access during the emergency.
 - Which health services are you still able to access during the emergency?
 - Which health services are you no longer able to access because of the emergency?
 - What can be done to support access to health services?

Examples of issues identified in DRC:

1. COVID-19 vaccine rumors
2. Poor use of COVID-19 prevention measures
3. Resistance of some community members and healthcare workers to be vaccinated against COVID-19
4. Low motivation of providers assigned to COVID-19 vaccination sites
5. Wrong information from some community members about the consequences of self-medication
6. Insufficient quantity of drinking water in some health facilities

2. A facilitator should note the issues generated by each group on flipchart paper, but only once a group has agreed on which issues should be listed. The group should cluster issues that are similar. For all issues, the facilitator should prompt for ideas to improve the issues.
3. Once the issues have been identified, the facilitator will lead the group through prioritizing the top 3-4 things to address that are impacting health services during the emergency. The group will name the issue, rank its priority, and give reasons for the ranking. The table below is a template for recording this information.

Note that there are different options that can be used to support the issue ranking, including using a number scale (0-5), descriptive words (low, medium, high) or (bad, okay, good) or even facial expressions (☹️, 😐, 😊). The last option may be particularly helpful in lower literacy populations.

Example of issue prioritization by group: Community members		
Issue	Priority (1 = highest)	Reasons
Many community members don't practice measures to prevent COVID-19	1	<ul style="list-style-type: none"> • Lack of awareness and acceptance of the importance of using COVID-19 prevention practices
Wrong information from some community members about the consequences of self-medication	1	<ul style="list-style-type: none"> • Poor information about the consequences of self-medication
Poor leadership in some health facilities is negatively impacting the quality of health services	2	<ul style="list-style-type: none"> • Weak leadership from health facility managers • Managers not following the recommendations from supervisors or instructions from the Ministry of Health • Lack of running water available in health facilities and sometimes women are asked to collect it

Example of issue prioritization by group: Healthcare workers		
Issue	Priority (1 = highest)	Reasons
Community members are not going to health facilities for services	1	<ul style="list-style-type: none">• There are many unofficial health and pharmaceutical dispensaries outside of the health system (e.g., traditional healers)• Low trust between community members and healthcare workers
Wrong information shared by some community members about the consequences of self-medication	2	<ul style="list-style-type: none">• Individuals have heard bad information and share it with others• The response has poor risk communication on the consequences of opting for self-care/use of non-medical remedies over the use of recommended prevention and treatment protocols by health experts
Community members are not practicing measures to prevent COVID-19	1	<ul style="list-style-type: none">• Lack of awareness and acceptance of the importance of complying with prevention practices
Lack of running water and other supplies make it difficult to follow infection prevention and control protocols	1	<ul style="list-style-type: none">• The health facility relies on a borehole, making it difficult to ensure a good water supply• Lack of water and other supplies prevent healthcare workers from following protocols

4. The groups can then be gathered together. The lead facilitator will thank the participants for their time and explain that the issues will be turned into indicators that will be scored at the next meeting. The facilitator and groups should then agree on the location, date, and time of the next meeting.

2. Indicator Development

Next, the project team will take the information from the discussion with community members and healthcare workers and combine issues into themes that are common across all the groups. These themes will then be changed into indicators included in a “scoring matrix”.

After the facilitation team creates the indicators and enters these into a scoring matrix template, the matrix will be shared so each group can score the indicators. To develop indicators, look at the themes that are related and aim to develop a statement that is neutral (neither suggesting something bad or good) so that it can be scored. For example, if there are concerns about having enough water and other supplies in health facilities so that people will not get sick, an example indicator can be: *Ability to implement infection, prevention, and control protocols in health facilities.*

In the DRC, example indicators from one health area included:

1. Level of attendance at the health facility
2. Level of communication between healthcare workers and the community
3. Drug supply quantities at the health facility

To help make sure that everyone understands the meaning of the indicators and agrees that these are the main indicators to prioritize, it can be helpful for facilitators to share the indicators with their groups for feedback before starting the scoring process. Facilitators should work together to update the matrix if anyone thinks changes should be made. Once a final matrix is agreed upon by group members, the group can proceed with the next step: indicator scoring.

You can see the example scoring matrix below that has example indicators for issues discussed in all groups.

Example of developing indicators from themes	
Theme	Indicator
Community members are not using health facilities for health services	Level of attendance at health facilities
Community members are not practicing prevention measures, including following protocols at health facilities	Community adherence to COVID-19 prevention practices and protocols
Some community members are spreading disinformation about the consequences of self-medication, increasing the use of self-care using non-medical remedies	Level of understanding in communities on the consequences of self-medication
Lack of running water and other supplies make it difficult to consistently follow infection prevention and control protocols	Ability to implement infection prevention and control protocols in health facilities

Example of developing a scoring matrix

Group:						
Date:						
Location:						
Indicator	Score					Reasons
	Very bad (1)	Bad (2)	Just okay (3)	Good (4)	Very good (5)	
Level of attendance at health facilities						
Community use of COVID-19 prevention practices						
Level of community understanding of the consequences of self-medication						
Ability to implement infection prevention and control protocols in health facilities						

3. Indicator Scoring

Facilitators will meet with their individual group (men, women, youth, healthcare workers) to score the indicators. Each group will first discuss and score the indicators in the matrix separately from the other groups. The different stages of this process provide opportunities for community listening and the tables help document content that can be used to inform advocacy and action planning with various influencers.

After community subgroups complete the scores, representatives from each group will come together to decide on scores to include in a combined matrix. The healthcare workers will complete the same exercise to create one scoring matrix representing their views. The scoring process is done to help participants apply a rating to the indicators to highlight which issues are most important to address.

Time required

1-1.5 hours

Materials needed and other preparation required

Flipchart paper and markers or pens

Steps: Session 1: Community group scoring of indicators by subgroups

1. The lead facilitator for each group welcomes participants, describes the activity, and its purpose.
2. The facilitator presents the indicators created by the facilitators in the scoring matrix.
3. Starting with the first indicator, the facilitator asks the group to give it a score. Make sure the group has agreed on a score before writing it. Check that the score best represents the views of *all members* of the group. Ask for the reason for the score and add it to the scoring matrix. For low scores, ask how the score can be improved. For high scores, ask how the score can be maintained.
4. Repeat the process for all indicators in the scoring matrix.

Steps: Session 2: Community group scoring of indicators representing all community groups

1. Each community subgroup selects a few representatives to join a discussion to consolidate the scores into one matrix.
2. Repeat the steps outlined above in order to complete one matrix that represents all community groups.

Steps: Session 3: Healthcare worker group scoring of indicators

1. Complete the steps outlined in Session 1 above to create a completed scoring matrix for the healthcare worker group.

Notes for Facilitators

For inclusiveness, the facilitator should encourage participants that seem to be quiet or are unable to speak up during the scoring process.

Example of scoring matrix completed by healthcare workers						
Group: Healthcare workers						
Date: 10/01/2020						
Location: Health area 1						
Indicator	Score					Reasons
	Very bad (1)	Bad (2)	Just okay (3)	Good (4)	Very good (5)	
Level of attendance at health facilities			X			<ul style="list-style-type: none"> Many community members do not think they need to go to the health facility Many community members go to traditional healers
Community use of COVID-19 prevention practices			X			<ul style="list-style-type: none"> Lack of awareness or acceptance of the importance of practicing COVID-19 prevention measures
Level of community understanding of the consequences of self-medication		X				<ul style="list-style-type: none"> Some community members are selling remedies, and some are spreading false information about choosing self-medication over visiting health facilities
Ability to implement infection prevention and control protocols in health facilities	X					<ul style="list-style-type: none"> Inconsistent water supply and lack of other supplies makes it difficult to follow protocols We sometimes do not have masks or gloves to wear when providing services



3.3 Advocacy and Action Planning

1. Interface Meeting Bringing Community Members and Healthcare Workers Together

The interface meeting is where healthcare workers and community members come together to talk about issues impacting health service delivery and use. In this meeting, community members and healthcare workers will each present their score card and discuss the reasons behind the indicator scores.

Questions are encouraged by both sides to help with understanding of the issues and perspectives on what is causing the issues. Good facilitation is required to avoid blame and create a space for respectful discussion. After the discussion, both groups will work together to develop a joint action plan to help address the priority issues.

What is NOT part of this process?

- It is NOT about finger-pointing or blaming.
- It is NOT supposed to create conflict.

Planning

The interface meeting will bring together participants from each group who have participated in the score card process along with other relevant influencers. It is important that key decision makers (community leaders, district officials, ministry officials, non-profit organizations, and other emergency responders) are present to provide feedback on the issues and take responsibility for supporting advocacy and actions to address issues, depending on their role.

Although the meeting should only take one day, it does require some planning, such as space for the event, transportation, payment, and meals. The implementing organizations should make sure to have a planning meeting with stakeholders to agree on meeting guidelines as well as to determine the location, date, and time of the interface meeting, to prepare logistics, such as purchasing supplies and ensuring access to transportation and food, and to prepare invitations for the event.

In the DRC, 5 medical providers, 5 non-medical providers, and 2 community members were selected to participate from each set of focus groups.

Time required

2.5-3 hours

Materials needed and other preparation required

- Flip charts from meetings with healthcare providers and community members, tape and flip chart paper and markers, enough for two stations per scoring matrix location
- Before the meeting, choose a place to have a “gallery”, where you will hang up the flip chart papers from the previous discussions. Participants in the interface meeting will walk through the “gallery” before working in groups.

Opening remarks, introductions, and review of the agenda

All facilitators should introduce themselves briefly. As an introduction exercise, participants may be invited to participate in an ice breaker, such as singing a song, telling a story from the community, or another activity that will help to build familiarity. Lastly, the project lead will review the agenda with participants, so they know what to expect from the meeting.

Review objectives and expected results

Next, a facilitator or the project lead can take participants through the objectives of the meeting:

During this interface meeting, we are gathering healthcare workers and community members who contributed to the scoring matrix process in each location to combine the results of the score cards. In this meeting, first we will do a “gallery” walkthrough. We posted the flipchart pages from each focus group on the walls. We will take some time so you can walk around and look at the ideas generated in each location and by each group. Then we will meet as a larger group, combining healthcare workers and community members from each location. Both community members and healthcare workers will have the opportunity to present their score card and the reasons for the scores provided for each indicator. We want to encourage discussion on the issues impacting services, the reasons contributing to these issues, and what can be done to make improvements. We will capture the discussion in a joint action plan that includes timelines and persons responsible for leading each action.

Then the lead will explain the expected results:

After discussing indicator scores, you will work on creating an action plan for your location. We will meet together in each location to evaluate progress towards the indicators and action plan.

Gallery presentation

Invite the participants to walk around your “gallery” and view the flip chart pages from each of the score cards. Although you will provide participants with the flip chart pages from the healthcare worker and community score cards in their location, participants may find inspiration looking at the results of the discussions in other locations, if available.



Presentations

The community members will present their indicators and scores and suggestions for improvement or maintaining performance. Next, healthcare workers will do the same.

Discussion

After the presentations, there should be an open dialogue where community members and healthcare workers can discuss their separate scores and reasoning. Each side will have the opportunity to ask and answer questions from others.



Advocacy and action planning

After the discussions, participants can jointly decide which issues to address first, listing issues on a flipchart in the desired order. Next to each issue, participants will write actions for improvement.

Facilitator's note: Remember to keep the group realistic. Ask questions like:

- What are the key issues we want to talk about?
- What issues are the most possible to improve?
- What is short-term and what is long-term?

Based on the discussion, participants can group similar issues together and categorize under a theme name.

Participants are invited to discuss each theme and to write suggested actions for improvement. A facilitator can support in completing a joint action plan using a template like the one below to capture suggested actions, the group or person responsible for each action, a timeline to complete each action, resources required and any other notes.

It is best to keep action plans realistic and within a timeline aligned with the emergency response and your project.

Example of joint action plan						
Priority theme (list each issue)	Action (activities needed to address the issue)	Who will lead it (name and institution)	With whom (name and institution)	Completion date (realistic)	Resources (what is needed to do the action)	Notes
Low use of health services	Community dialogues Household visits	Health centers A and B with support from CARE	Local health improvement committee Community health workers	7/1/2022	Funding Transport Job aids and community dialogue tools	
Strengthened infection prevention and control protocols in health facilities	Infection prevention and control refresher training for healthcare workers Installation of handwashing stations	Health center committee Health center manager Local authority in charge of water supply		5/5/2022	More infection prevention materials and supplies/ infection prevention and control kits Handwashing stations	

Selecting a task team and next steps

To monitor progress on the action plans, project staff can ask participants to volunteer or nominate others to participate in a task team.

Organizers can also ask participants about joining the next interface meetings. In these meetings, community members and healthcare workers will re-score the indicators, which can be revised to reflect new or more important issues, and revisit and update action plans. It is important for the project team to discuss how this work will continue moving forward with key influencers, such as local government authorities and other emergency respondents, and agree on roles and responsibilities to support the process. The process will also be supported by the task team.

Closing remarks

Thank participants for their participation and let them know that organizers will contact them to have another meeting with this group to review and rescore the indicators and revisit and update the action plans.





2. Ongoing Community Dialogues

Ongoing community dialogues can be an effective strategy to address issues that relate to beliefs, attitudes, and practices that impact health during an emergency. This approach is based on self-reflection and discussion by participants. Creating a safe space for reflection and dialogue is essential to the success of this approach.

The purpose of the sessions is to encourage active participation in reflective dialogue. This provides an opportunity for community members to reflect on traditions and practices that create inequalities and barriers to services, including for women and girls. These sessions can identify attitudes and practices that conflict with recommended practices to prevent and respond to health emergencies.

CARE's Global Social Analysis and Action manual provides guidance on implementing community dialogues. If you are interested to learn more, you can access the manual online ([click here](#)).

Example: Community dialogues to explore and support the practice of a “safe and dignified burial”

To explore and support the practice of a “safe and dignified burial” - the community dialogue and reflection process starts from talking about existing “traditional” burial practice. *What* - expectations from different members of the family and community and *why* - the underlying reason or assumptions behind the practice.

In the DRC, during the Ebola outbreak, one tradition identified was that women were expected to cry over a dead loved one's body to express their love, which put them at greater risk of contracting Ebola. The Social Analysis and Action process facilitates reflection on the implications of this type of practice, building awareness of negative consequences, and exploring unfair aspects of the practice using different tools and questions; encouraging the community to think of good and bad things about the practice, explore alternative ways of showing love and respect to the dead, and come up with an action plan to change or avoid the practice.

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Annexes

Annex 1. Social Mapping Notetaking Template

Resource	Sub-group	Reason for difference in access
1.	Men	
	Women	
	Youth	
	Others (specify):	
2.	Men	
	Women	
	Youth	
	Others (specify):	
3.	Men	
	Women	
	Youth	
	Others (specify):	
4.	Men	
	Women	
	Youth	
	Others (specify):	
5.	Men	
	Women	
	Youth	
	Others (specify):	

Annex 2. Focus Groups with Community Members or Healthcare Workers Notetaking Template

Session information	Health zone: Health area: Date:
Total number of participants	Total: Male: Female:
Participants by group	Adolescents (<19 years): Men: Women: Medical healthcare workers: Non-medical healthcare workers: Others (specify):
Names of facilitators	
Data collection methods	
How was the discussion today?	
What are some important points from the discussion?	
What did you learn from the discussion?	
What were the main difficulties during the discussion?	
Which questions from participants or the facilitators helped to guide the discussion?	
Is a follow up discussion necessary?	

Annex 3. Suggested Documentation/Report on the Focus Groups Held with Community Members or Healthcare Workers

Location
Date(s)

Title

- I. Introduction *(narrative)*
- II. Background and rationale
 - General and specific objectives
 - Expected results
 - Methodology
 - Materials and logistics used

Date and time	Location	Activities	Persons responsible

- III. Summary of results by focus group *(narrative)*

Here are the results of the by focus group *(add a new section for each focus group)*

Location	Domain 1	Domain 2	Domain 3	Lessons learned, identified belief, norm, or issue
Location #1	Question 1 <i>(Fill responses)</i> Question 2 <i>(Fill responses)</i>	Question 1 <i>(Fill responses)</i> Question 2 <i>(Fill responses)</i>	Question 1 <i>(Fill responses)</i> Question 2 <i>(Fill responses)</i>	
Location #2	Question 1 <i>(Fill responses)</i> Question 2 <i>(Fill responses)</i>	Question 1 <i>(Fill responses)</i> Question 2 <i>(Fill responses)</i>	Question 1 <i>(Fill responses)</i> Question 2 <i>(Fill responses)</i>	

- IV. Priority beliefs/norms/issues identified *(narrative)*
- V. Lessons learned *(narrative)*
- VI. Challenges *(narrative)*

NOTES

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CARE USA

151 Ellis Street, NE
Atlanta, GA 30303
T) 404-681-2552
F) 404-589-2650

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