Applying the Care Group Model in Relief Contexts

Case Studies in South Sudan and Somalia

BY

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DECLARATION

I declare that "*Applying the Care Group Model in Relief Contexts: Case Studies in South Sudan and Somalia"* is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the thesis to originality checking software. The result summary is attached.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

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ABSTRACT

This study analyses the application of a community based intervention, the Care Group (CG) model, in relief work in Somalia and South Sudan. On the basis of expert interviews and a variety of documents it was researched whether the CG model is applicable to the context mentioned or if adaptations would be necessary.

An increase in prolonged crises challenges humanitarian action to adapt relief work to longer-term interventions. The concept of combining the strengths of development cooperation and humanitarian action - Linking Relief, Rehabilitation and Development - is looked at in this study. Furthermore, for example, the asset-based community development approach, humanitarian work and characteristics of a protracted crisis were explored as the theoretical background.

The findings and the conclusion of this research may provide inputs for other humanitarian NGOs that are working in chronic conflict situations and being confronted with the need to introduce a long-term method for Behaviour Change Communication.

KEY TERMS

Care Group Model; Asset Based Community Development; protracted crisis; Linking Relief, Rehabilitation and Development; humanitarian action; community based intervention; relief work; Somalia; South Sudan; Behaviour Change Communication

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ABBREVIATIONS

ABCD	Asset-based Community Development
BCC	Behaviour Change Communication
CFS	Committee on World Food Security
CG	Care Group
DFID	Department for International Development (UK)
DRR	Disaster Risk Reduction
ECHO	European Commission's Humanitarian Aid and Civil Protection Department
EU	European Union
FAO	Food and Agriculture Organisation of the United Nations
FH	Food for the Hungry
ICRC	International Committee of the Red Cross
ICG	International Crisis Group
IDP	Internally Displaced Person
IFAD	International Fund for Agricultural Development
IFRC	International Federation of Red Cross and Red Crescent Societies
IMC	International Medical Corps
IYCF	Infant and Young Child Feeding
KPC	Knowledge, Practice and Coverage
LRRD	Linking Relief, Rehabilitation and Development
MDG	Millennium Development Goal
NGO	Non-Governmental Organisation
ODI	Overseas Development Institute
SDG	Sustainable Development Goal
SMART	Standardized Monitoring and Assessment of Relief and Transitions (survey)
WASH	Water, Sanitation, Hygiene
WFP	World Food Program
WR	World Relief

CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1 Introduction

This study focuses on the application of a community based intervention in relief work. The application of the Care Group (CG) model within the work of Medair (a Swiss humanitarian NGO) in Somalia and South Sudan has served as an example for the case studies.

First an overview of the study's background will be given, followed by the problem statement, including the primary as well as the secondary research objectives.

1.2 Background to the research problem

According to the European Commission's Humanitarian Aid and Civil Protection department (ECHO), 50 million people are currently living in conflict zones (ECHO 2015:3). Most of these conflicts became so-called chronic or protracted crises. The Humanitarian Policy Group at the Overseas Development Institute (ODI) defines a protracted crisis as a persistent situation of political instability and military conflicts combined with socio-economic conditions that imperil the lives and livelihoods of a significant portion of the population (Jones 2004:15). Every protracted crisis is different, but in most cases, it also increases displacement in addition to negative effects on livelihoods, health and food security (CFS 2015:2). This results in great suffering and loss of life, particularly for the most vulnerable and poorest people in developing countries (EU 2013:1).

The author has had the opportunity to work for Medair[1], a Swiss emergency and relief organisation, and learned about the challenges of working in chronic crises. Medair implements programmes in countries like South Sudan and Somalia[2], both of which are fragile contexts and face protracted conflict situations. In both contexts, people have no easy access to food, water, health care and so on. Humanitarian aid[3] has to provide these basic essentials. Hu-

[1] More about Medair in section 3.3.
[2] More on South Sudan and Somalia in sections 3.1 and 3.2.
[3] More about humanitarian action in section 2.5.

manitarian NGOs are exceedingly challenged in contexts of chronic crises, and their very important immediate life-saving action has to be complemented with long-term development interventions. In his opening words at the World Humanitarian Summit 2016 in Istanbul, the Secretary-General of the United Nations, Ban Ki-moon, once again emphasised the importance of bringing development work and humanitarian action closer together.

> I call on development and humanitarian organisations to work more closely together, based on shared priorities and collective outcomes, to meet the long-term needs of millions of people in crisis (UN 2016a).

According to his summary at the closing ceremony,

> […] humanitarian and development partners agreed on a new way of working aimed at reducing the need for humanitarian action by investing in resilient communities and stable societies (UN 2016b).

The humanitarian NGO Medair, focuses on relief and recovery services in the world's most remote and devastated places. It started its work in Somalia in 2008, has worked in South Sudan since 1991 (Medair 2015c), and implemented the CG model[4] in both countries along with relief work and recovery services (Medair 2015b). Although the CG model is a development model, Medair applies it in South Sudan and Somalia in a relief situation. The aim is to support women in reducing malnutrition in their children and in improving health and hygiene practices. According to Medair's Senior Advisor for Health and Nutrition, the decision in favour of the Care Group Model has been made for two reasons. Firstly, the model seeks to build resilience and to empower communities. Secondly, the CG model has been proven as an effective way of promoting health and hygiene on a grassroots basis with a long-lasting impact – even after the implementing NGO has left. She referred to the project evaluations of CORE Group members, a network for community health worldwide, who are experienced in working with the CG model.

Medair's Senior Advisor for Health and Nutrition supported research on the CG model in a relief context, that is, the effectiveness of a community based intervention in relief work. Not much qualitative data exists, however, for evaluating the experiences of the relief workers in South Sudan and Somalia, of

[4] More on the Care Group Model in section 2.4.

adapting of the CG model. This leads to the specific research problem of this study.

1.3 Research problem

On the basis of the background, the research problem is whether and how the Care Group Model can be applied in a relief context, characterised by protracted crisis, in light of its original design and methodology for a development setting. Medair's work with the CG model in Somalia and South Sudan served as the case studies. Medair is regularly evaluating its work with CGs, but the organisation had never yet undertaken an analysis as described above. Research on this topic may contribute to other cases for applying the CG model in a chronic crisis where long-term relief work is needed and building the resilience of communities is crucial for their future.

1.4 Research objectives

The Problem Statement given above leads to the following primary research objective:

Analysis of the application of the Care Group Model in a relief context in light of its original design and methodology for a development setting.

The following secondary objectives contribute to achieving the primary research objective:

1) To study the asset-based community development, on the basis of selected literature, as the theoretical framework in order to place the Care Group Model into context.
2) To explain the origin, focus and method of the Care Group Model.
3) To contrast the application of the Care Group Model to the context of South Sudan and of Somalia, regarding the challenges and successes.
4) To examine on the basis of the case study which key elements of the Care Group Model can be applied to the context of a protracted crisis.

5) To debate the results of the analysis of the case study and to formulate general recommendations for applying the Care Group Model to the context of a protracted crisis.

1.5 Limitations and scope of the study

Since the case study focused on the work of Medair in South Sudan and Somalia, the scope of this master's dissertation was partially predetermined:

Geographical focus: The study focused on the specific project areas in Somalia and in South Sudan. Medair has implemented the CG model in both of these countries.

Context: Both countries face chronic conflict. This made it possible to compare the collected data (interviews, project documents, evaluations). The complex situation crucially influences the relief work of Medair, which is why the study focused on the context of chronic conflicts and protracted crises.

Medair as source of information and data: The study focused on the experiences of Medair, therefore its documents and its staff were the primary sources of information concerning the qualitative research. This could be considered a limitation of the study because the interview partners were from the same organisation and therefore have a limited view in some ways. Medair employs international and national field staff, and all of them speak English. Interviews with local staff compensated for the limitation of not interviewing beneficiaries directly. As they know their culture, current situation and history best, they prove to be a solid source of information.

Neutrality: Medair as a humanitarian organisation is obliged to remain neutral. This principle could easily be endangered through, for example: political statements. The interview questions had therefore to be formulated with respect to this principle and resulting restrictions have had to be accepted.

Security issues: The insecurity of the context necessitates restrictions for visitors. Conducting the interviews on site was too challenging. Interviews via Skype was the most feasible way to get in contact with the national and international field staff of Medair.

Size of sample: nine expert interviews with Medair staff or former Medair staff. Their gender, economic situation, age or educational background were deemed secondary. Their working experience with the CG model counted paramount for the interviews. The interview data was triangulated with the project documents of Medair. Medair staff were the main source of data because of the research objective: focus has been on the application of the CG model and not on the impact.

1.6 Importance of the study

The study investigated how the CG model as a development model can be applied to relief contexts and serve communities in protracted crises to strengthen their resilience in particular areas of life (for example: health). This investigation provides an overview of ongoing discussions about LRRD, as well as its impact on the field work. It describes how Medair, in the case study, handles the application of a development model in a relief context and what the required adaptations are. The findings and the conclusions drawn from the collected data have provided general recommendations for the work with CGs in contexts similar to South Sudan and Somalia, and may contribute to other cases for applying the CG model in a chronic crisis where long-term relief work is needed. The case study serves as an example of how crisis-affected persons may benefit from the humanitarian assistance of Medair in the long run.

1.7 Research methodology and design

This study followed a qualitative research method for investigating the application of a development model in a relief context in practice and for putting the findings back into practice. Organisational functioning and cultural phenomena as well as context related obstacles and decisions can best be explored with qualitative research (Strauss & Corbin 1998:11).

The qualitative research design served as a framework for all intended steps of this study, for gathering and later analysing the necessary data and as a blueprint that the researcher tried to follow (De Munck 2009:11). When defining the research design not only the objectives, but methods, tools, time and

financial resources had to be taken into consideration (Flick 2003:264). An overview of the executed steps looks as follows:

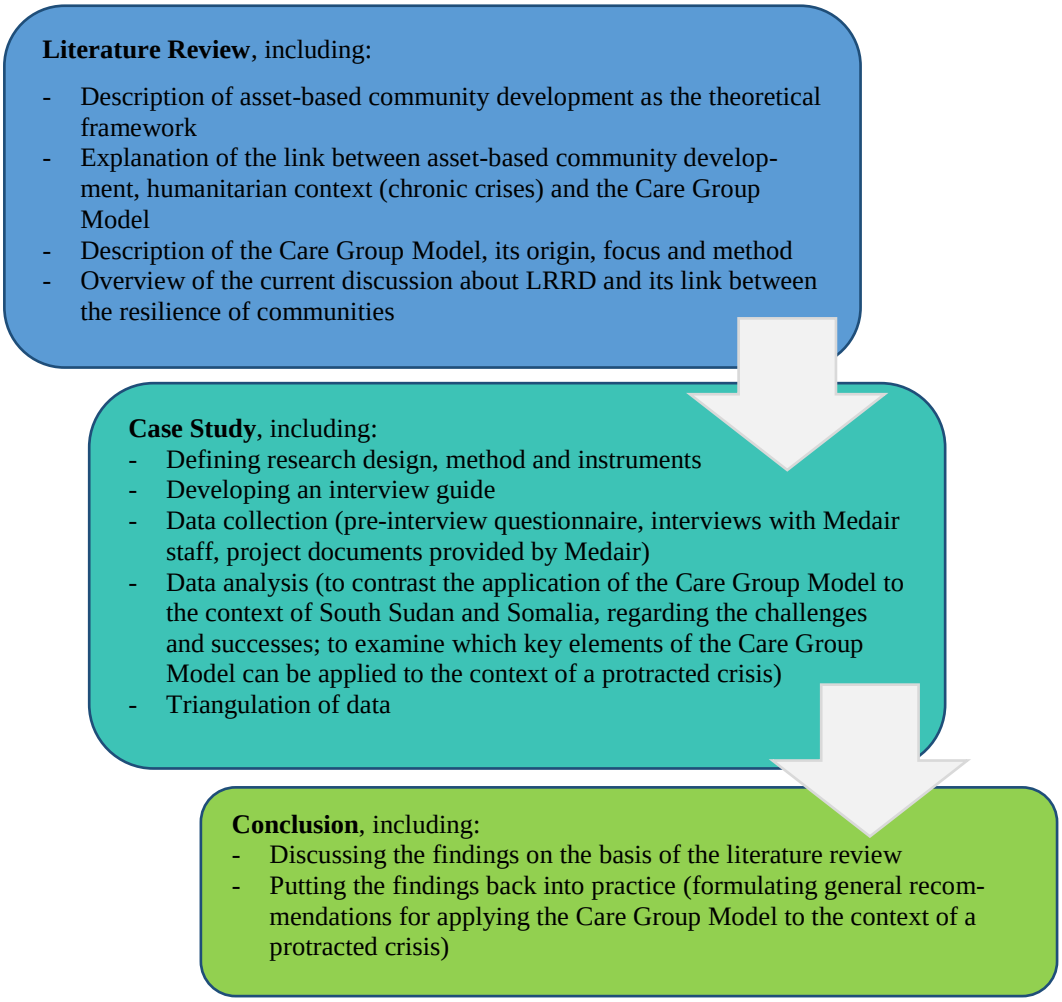

FIGURE 1.1: ACTION STEPS OF THE RESEARCH

Case Study

Case studies aim to gain insights into an individual organisation or situation and to constitute, *inter alia*, a representative example (Newby 2010:253). The available research objective, the *"Analysis of the application of the Care Group Model in a relief context in light of its original design and methodology for a development setting"* and its secondary objectives indicated the use of the case study strategy. The case study

> […] offers us an opportunity to maximise the cultural and contextual realities 'embedded' in the international setting of the research and to produce analyses of depth and complexity (Stephens 2009:47).

The intention to collect the data in the field of action and bring the findings back into practice made a case study an appropriate strategy for this research, because it is 'strong in reality' (Stephens 2009:46).

1.8 Data Sources and Access

This master's dissertation used both primary and secondary data sources. Literature about for example: LRRD, asset-based community development, the history and context of Somalia and South Sudan formed the theoretical basis of the case study. Access was ensured, *inter alia*, through the student's membership of the central library in Zurich and the internet. The CORE group[5] was one of the main sources for documents describing the concept of the CG model, as well as project documents of and evaluations conducted by Medair. For outlining the case study, a reconstruction of the project status of the work of Medair in Somalia and South Sudan was fundamental. The organisation provided access to project documents, evaluations, and reports.

Empirical Research (primary data) was conducted to investigate the application of the CG model in a relief work context. Local and international staff of Medair were interviewed via Skype. The decision to use the internet had been made because of security issues and financial reasons. The difficulties attendant upon accessing the field work of Medair in Somalia and South Sudan (for example: ongoing armed conflicts made travelling to the communities difficult and more often impossible) also complicated the carrying out of Focus Group Discussions. The questions for these semi-structured interviews had crystallised after the theory of the CG model was studied and brought together with the analysis of the context of South Sudan and Somalia. All interviews were recorded for the transcription. The interviews were not about the personal lives of the interviewees, but about *their experiences with and knowledge of the CG model*. The participants are therefore experts, and the interview guide was more structured than in a narrative interview (Helfferich 2009:164). The statements and information were decoded by the researcher (Helfferich 2009:166).

[5] See www.coregroup.org

Sample size and sampling technique

There are six Medair staff involved in the work with CGs: three in Somalia and three in South Sudan. Medair's Senior Health and Nutrition Advisor also agreed to be interviewed. One Medair staff member who had previously worked in South Sudan and a former Medair staff member who had worked in Somalia and in South Sudan were also interesting interview partners. Due to this staff situation, a sample size of nine interviews was defined. They are very experienced in working with the CG model within the context of either South Sudan or Somalia. Because this master's dissertation analysed the application of the CG model in a relief work context, the collected data from the interviews was triangulated with project documents and evaluations. The samples were selected on a targeted basis due to the staff situation of Medair in South Sudan and Somalia, and were defined before starting the field research (*selective sampling technique*). Preliminary theoretical considerations determined relevant characteristics of the case selection (Kelle & Kluge 2010:50). Minimising the distinctions of the samples increased the probability of finding similar data and of confirming their relevance (Kelle & Kluge 2010:47f). The balance between international and national staff had to be maintained as much as possible. Cultural insights from national staff were particularly valuable, and their experiences and knowledge were sought in the interviews. The participants' age, gender, religion etcetera were not decisive factors for defining the samples in this research.

When working with the selective sampling technique, the data was analysed after conducting and transcribing all interviews (Kelle & Kluge 2010:50).

1.9 Data Analysis

The interviews were conducted via Skype and voice-recorded as an mp3 file. In a second step, the records were transcribed. All former and current Medair staff could express themselves in English, which enabled the student to transcribe the interviews herself. This simultaneous procedure allowed her to become familiar with the data.

The data analysis followed the grounded theory approach. In different so-called coding cycles the data had to be broken down that enabled the researcher to get findings (Strauss & Corbin 1998:12f). It is a holistic approach (Newby 2010:488), that made it appropriate for analysing the data of this research. The application of the CG model in a relief work context is holistic as well which required a corresponding data analysis approach.

The data gained from the interviews was evaluated using the software "Maxqda12" and was triangulated with project documents (reports, proposals, evaluations, surveys) made available by Medair. The outcomes were discussed on the basis of the preceding literature review that allowed conclusions to be drawn which related to the research objective: from practice back into practice.

1.10 Validity and Reliability

Using the approaches and techniques appropriately, as well as the ongoing self-reflection of the researcher, contributed to the validity and reliability of the research (Newby 2010:121f). Having a supervisor and working with experienced staff within Medair provided guidance and support for the student's ongoing self-reflection.

The principle of triangulation allowed integration of several methods and combination of different sources of data (Flick 2009:445). This process sought the validation of for example: an outcome through two different sources (Newby 2010:122) and was applied in this research because of a limited number of suitable Medair staff for the interviews. A case study seeks the usage of a variety of sources (for example: documentary sources, statistics, external reports, evaluations, data collected from interviews or observations etc.) so that the findings can be triangulated appropriately (Newby, 2010:52). The different roles, tasks and cultural backgrounds of the interviewees, as well as their individual experience in applying the CG model in a relief work setting, contributed to the triangulation.

Moreover, transparency of the entire research (data collection, analysis, documenting the findings and drawing conclusions) was crucial for delivering

quality in a qualitative research study (Newby 2010:455). Awareness of the importance of being transparent in every step of the research has had a lasting impact on the student's approach.

1.11 Ethical Considerations

Protecting the rights, dignity and safety of the interviewees are the main issues when conducting a qualitative research (King and Horrocks 2010:105). Although the research took place within Medair and the staff is not regarded as vulnerable (for example: all participants are older than 18 years), their rights had to be protected. They participated voluntarily and have had the right to withdraw their participation at any time without revealing their reasons.

A critical point could have been the different management levels of the participants. This might entail the risk that the interviewees do not feel free to speak openly, due to not wanting to criticise a superior for example. The employees had to be informed about the research and its purpose (informed consent) before the data collection took place. This included the assurance that the data an interviewee provided was not to be used for evaluating his or her performance as a humanitarian worker. Participants must not be put at a disadvantage when being part of the research. This was the student's duty and preconditions had to be created accordingly.

1.12 Definition of key concepts

The description of the key words is intended to give guidance on their use in this master's dissertation.

Care Group Model

This development model has been initiated by World Relief in the 1990s as a community-based health project in a development setting in Mozambique (World Relief 2004:1). The NGO staff provides training, supervision and support to the volunteers who are elected by the community and who are each responsible for ten to fifteen women in the community. They instruct the group in better health practices, which has a multiplier effect, strengthening the

commitment to health activities and group solidarity (World Relief 2004:5f). The improved health behaviour builds resilience in the community.

Asset-based Community Development

Community development is a people-centred approach and seeks to empower communities for their own development (Monaheng 2000:127f). However, the conventional community development approach focuses on the needs, problems or issues of a community, whereas the asset-based approach builds and strengthens the community's assets and resources, without ignoring the existing difficulties (Haines 2009:39).

Linking Relief, Rehabilitation and Development (LRRD)

This concept originated in the 1980s and was formulated by the Commission of the European Communities in 1996 and 2001. The aim was to integrate long-term development issues in short-term relief mechanisms and to strengthen coping strategies and disaster preparedness through adapted development policies (Commission of the European Communities 2001:3).

Medair

Medair is an international humanitarian NGO founded in 1989, based in Switzerland. Medair's mission, to relieve human suffering in some of the world's most remote and devastated places, focuses on health care and nutrition; safe water, sanitation and hygiene; and, shelter and infrastructure. The organisation is signatory to the Code of Conduct of the International Committee of the Red Cross. Medair has 99 staff members (88 full-time equivalents) working in the Headquarters in Switzerland and 1142 field staff, of whom 998 are locally recruited. The field staff are at present divided (according to the size of the respective project) into teams in Afghanistan, Democratic Republic of Congo, Haiti, Iraq, Jordan, Lebanon, Madagascar, Nepal, Philippines, Sierra Leone, Somalia, South Sudan and Syria (Medair 2016).

Protracted Crisis/Chronic Conflict

The Humanitarian Policy Group at the Overseas Development Institute (ODI) defines a protracted crisis as a persistent situation of political instability and

military conflicts combined with socio-economic conditions that imperil the lives and livelihoods of a significant portion of the population (Jones 2004:15).

According to Hans Guenther Brauch (2011:104), underdevelopment, conflicts and human rights violations, hazards and disasters and the violation of basic laws (lack of good governance) are the four pillars of human insecurity. They are often interrelated and cause protracted crisis.

Resilience

Resilience has been defined by the multi-agency Resilience Measurement Technical Working Group of the Food Security Information Network as

> […] the capacity to ensure that shocks and stressors do not have long-lasting adverse development consequences (WFP 2015:3).

That ability refers to a system, society, community or individual. The converse of resilience is vulnerability that describes the degree of susceptibility and inability to cope with shocks and stressors (Pasteur 2011:113). It is also connected to social (for example: belonging to a low caste) and economic (for example: lack of resources or education) conditions of people (Pasteur 2011:11).

1.13 Chapter layout

This study is subdivided into six chapters that correspond with the current UNISA model and are summarized as follows.

Chapter 1

After a brief overview about the background of the research problem, a general outlook is given about the intended steps to reach the defined primary research objective and its secondary objectives. Following the general outlook an introduction to the limitations of the study and the research methodology including the data analysis are briefly addressed. The chapter closes with ethical considerations, key concepts and the chapter layout.

Chapter 2

This chapter provides a discussion of the literature that is relevant to this study. Asset-based community development provides the theoretical frame-

work. In addition, the CG model is described, and humanitarian action and the link between relief and development work (LRRD) is examined.

Chapter 3

This chapter gives the background to the study. Different aspects of Somalia's and South Sudan's contexts as well as the current situation are described. The last part of this section forms a brief introduction to Medair as the implementing NGO in this study as well as Medair's interventions in Somalia and South Sudan.

Chapter 4

This chapter describes the path towards the data collection, the data collection itself, and the analysis of the information gathered. The research design served as a framework, for all intended steps of this study, for gathering, analysing, and triangulating the necessary data and finally reaching the research objective.

Chapter 5

This Chapter contains the description and the results of the data analysis. Firstly, the data gained through the expert interviews is focused upon as well as on the process and the findings of the different coding cycles (open coding, axial coding and selective coding). The coding cycles were executed according to the Grounded Theory, the data analysis method of this study. Secondly, the findings of the document analysis and the triangulation of the data is added and brought in relation with the research objectives.

Chapter 6

Chapter 6 reflects upon the research methodology and summarises the research's findings in relation to the primary research objective, complemented by the secondary research objectives. Furthermore, recommendations are formulated for the field of action developed from the case study. The chapter includes a list of topics for further research.

1.14 Conclusion

This chapter has introduced the study and provides the background of the research. The research objectives were deduced from the background of the research problem and were complemented with elaboration on the scope and limitation of the study together with ethical considerations. The intended steps of this research for finally reaching the objectives, were outlined as well.

The next chapter provides the literature review that is the theoretical foundation of this study.

CHAPTER TWO: COMMUNITY BASED INTERVENTION IN RELIEF WORK: AN OVERVIEW OF INTERNATIONAL LITERATURE

2.1 Introduction

This chapter provides a discussion of the literature that is relevant to this study. Besides a short description of the CG model, humanitarian action and the link between relief and development work (LRRD) will be looked at. Asset-based community development (ABCD) provides the theoretical framework of this master's dissertation and it will be elaborated upon after giving an introduction about community development in general.

Basic values of community development participation and empowerment (Ledwith 2011:2; Pawar 2014:91) shall be looked at before describing the CGM.

2.2 An introduction to community development

In the past decades, the understanding of international development cooperation has changed considerably. World politics, as well as acquired knowledge and experiences, played a major role in these constant changes. Roughly outlined, the development approaches changed over the decades from pure technology transfer to the basic needs approach to concepts of people-centred development (Kroeck 2015:18f).

As a basis for this master's dissertation, the thoughts of Sangmeister and Schoenstedt, concerning the aim of human development interventions, are influential. They define an overarching objective of all development policies and measure the global improvement of people's living conditions. These improvements should culminate in strengthening the individual's self-responsibility and opportunities for participation, including an active role in society (Sangmeister & Schoenstedt 2009:142). This is typical for a people-centred or bottom-up approach such as community development. According to Robert Chambers (1997:129), community development indicates that the role of a development worker is to empower the local people "to express,

share and extend their knowledge". He and other development practitioners and professors (for example: John Friedmann, David Korten) began from the 1980s to articulate these people-centred approaches (Myers 2011:28) as criticism of development from above. Ledwith observed that a western worldview that is "unhealthily preoccupied with profit" has been constructed (Ledwith 2011:2), and still applies.

> At the same time as that profit imperative is both undermining human wellbeing and destroying the planet that is key to our very survival, we also see eruptions of grassroots action for social change spreading around the world (Ledwith 2011:2).

Specific socio-cultural conditions, mobilising indigenous natural and human resources, as well as appropriate technology were defined as crucial in the above-mentioned grassroots action or bottom-up approaches (Potter, Binns, Elliot, Smith 2008:117).

Community development has its roots in the 19th century when various social movements emerged. It received recognition as a practice after 1950/60 when antipoverty activities had arisen seeking multiple changes within the communities. These improvements shall include the physical, environmental, social and economic dimension (Phillips & Pittman 2009:4). Greig, Hulme and Turner (2007:234) name a specific project that was carried out in the late 1940s in Uttar Pradesh, India, as the starting point of community development. Although successfully mobilizing communities in the beginning, the program's unhealthily preoccupied with profit" was short-lived (Greig, Hulme & Turner 2007:234). Nonetheless, community development has established itself during the past fifty years as an approach to eradicate poverty, although no common definition exists (De Beer & Swanepoel 2011:34; Phillips & Pittman 2009:5). This stems from the fact that community development is interdisciplinary and is approached in many ways (Phillips & Pittman 2009:5). De Beer and Swanepoel (2011:47) describe community development as "a collective grassroots action to tackle felt concrete needs". They assume that community development is a process (De Beer & Swanepoel 2011:44). Several authors agree (Phillips & Pittman 2009:6; Brennan et al. 2014), although according to Brennan et al. (2014), the practitioners see community development in general more as an outcome rather than a process. Ife (2013:182)

urges caution not to put the outcomes above the process. (Ife 2013:159), because the process itself is important (Ife 2013:182). It implies that community development requires a long-term vision. Expecting immediate results is against the nature of community development (Pawar 2014:100). Concerning the time factor, Mattessich states, that even when social networks and the community's capacity have developed,

> […] sustaining those networks and the social capacity requires on-going effort (Mattessich 2009:55).

Community development is never static but influenced by the corresponding context with its prevailing politics, local experiences, cultural factors and so on, hence it is a "constantly developing theory in action" (Ledwith 2011:14).

Besides defining community development, the question has to be raised as to what a community is. Pawar (2014:39) states that to define "community" is rather difficult, due to its dynamic and complex nature. Gujit and Shah even question the use of the term "community", because

> […] simplistic understandings of 'communities' see them as homogeneous, static and harmonious units within which people share common interests and needs (cited in Cooke & Kothari 2001:6).

Describing the characteristics of "community" would be more appropriate than to define "community", ergo Pawar (2014:40;41) characterizes three types of contemporary communities, wherein overlapping or connections are possible:

- geographic or locally-based community (for example: village communities)
- target- and/or interest-based community (for example: common background, religion, hobbies, age, etc.)
- virtual community (for example: social media)

Ife (2013:112) agrees with Pawar not to define "community" in a formal way and similarly categorizes geographical, functional and on-line communities (Ife 2013:114). Furthermore, he describes five manifestations of that "form of social organisation" (Ife 2013:112f):

- Human scale (people know each other or can get to know each other; structures are small enough that people own and control them; interactions are accessible to all)
- Identity and belonging (people belong to the community as members, which gives a sense of identity)

- Obligations (it is expected that the members contribute in some ways to the maintenance of their community)
- *Gemeinschaft* (individuals are able to contribute with their specific talents and abilities for the benefit of the whole community)
- Culture (people are active producers of their community-based culture; broad-based participation is possible)

These above-mentioned points correspond with Phillips and Pittman's conclusion, drawn from different attempts at defining "community", that the community's main characteristic is its people and the connections among them (Philipps & Pittman 2009:6). This implies that a community is a complex fabric with various aspects that have to be taken into account when it comes to community development interventions. Understanding the local development environment and what possibly hinders or supports development initiatives is therefore crucial (De Beer & Swanepoel 2011:15f; Pawar 2014:59f).

2.3 Asset-based Community Development (ABCD)

According to Haines (2009:39f), the more conventional way to approach community development concentrates on the problems of a community. It is needs-based. The alternative community development approach is asset-based. Instead of pointing to issues and needs of a community, its assets and strengths are in focus – without ignoring the difficulties a community faces.

After analysing narratives about community development, John Kretzmann and John McKnight wrote their ground-breaking book "Building Communities from the Inside Out: Asset-based Community Development" in 1993. ABCD gained wide acceptance as a result of this study (Raniga 2014:75). Kretzmann and McKnight state that every community has the capacity to design and sustain their own development process if the community members are willing to invest themselves and their resources. The authors have seen significant changes within communities when the process of community development was from bottom up and from inside out (Kretzmann & McKnight 1993:5).

The starting point of the community development efforts are marked by

> […] discovering and mobilizing the resources and strengths, or assets, to be found in even the most challenged communities (Kretzmann, McKnight, Dobrowolski & Puntenney 2005:31).

Individuals, associations and institutions form the three major categories of a community's assets (Kretzmann & McKnight 1993:8). It is the strength of the relationships among them that makes community building from the inside out possible, which implies that network building is crucial in the ABCD (Kretzmann & McKnight 1993:346).

> The gifts of individuals become valuable when they are connected to someone. Associations become powerful when they connect the gifts of many individuals. Associations become even more powerful when they are connected to other associations (McKnight 2013:13).

Relationships and networks within the community are also referred to as social capital or social capacity (Phillips & Pittman 2009:6; Mattessich 2009:49).
Other authors divide the community's assets into different categories from those of Kretzmann and McKnight. Phillips and Pittman (2009:6) for example, name the following asset groups:

- Human capital (skills, experiences)
- Physical capital (infrastructure, buildings)
- Financial capital (micro loan funds, community financial institutions)
- Environmental capital (natural resources, recreational opportunities)

A further possible way of dividing the community's assets into categories is provided by De Beer and Swanepoel (2011:181-183):

- Natural resources (what Mother Nature provides)
- Manufactured resources (artificially made, for example: roads, shops, sanitary systems, money)
- Human resources (members of the community)
- Organisational/entrepreneurial resources (ability to structure its existence)

As outlined above, discovering the assets of a community is the starting point of ABCD. It is the local holistic context that determines the community development process (De Beer & Swanepoel 2011:54). It is therefore necessary to discover and eventually to mobilize the community's unique assets (Kretzmann, McKnight, Dobrowolski & Puntenney 2005:31) that inspires positive action for change (Mathie & Cunningham 2002:5). The underlying convic-

tion is that every community has resources, regardless of its poverty (De Beer & Swanepoel 2011:180). Basic values of community development are participation and empowerment. They seek to strengthen a community's existing resources and abilities (Pawar 2014:108; De Beer & Swanepoel 2011:26) and to let the community members become the major role-players in developing their own community (Monaheng 2000:129; De Beer & Swanepoel 2011:51).

2.3.1 Participation

The daily life of local people with their hopes, concerns, history, values and culture forms the initial context for sustainable change (Ledwith 2011:2;51). Only if the community members are the major role-players in community development (Monaheng 2000:129) does participation take place (De Beer & Swanepoel 2011:51). Instead of involving the community in pre-planned projects and discussing its mobilisation, the focus shall be on the community's empowerment and self-directed decision-making (De Beer & Swanepoel 2011:37).

To bring about genuine participation is not a simple endeavour. The history of community participation shows that the concept has sometimes been limited to consultation rather than community-generated decision-making (Mathie & Cunningham 2002:11) or even tokenism when communities were co-opted and found themselves part of a system they were opposing (Ife 2013:172; Rahnema 2010:138). White (1996:6) agrees that participation has the potential to challenge patterns of dominance on the one hand but may, on the other hand, strengthen existing power relations. She emphasises furthermore that there are many unfree reasons for participation, contrary to a genuine interest in a project (White 1996:14). Participation often was, and is, a means to "bring in" people to the development process which assumes that people are "passive objects of programmes and projects that were designed and implemented from outside" (White 1996:14). Leal therefore criticises the "development industry" and clearly states that participation must take place "within the social, political and cultural context of grassroots struggle" (Leal 2007:544). If the latter happens, participation and empowerment is seen as the basis of the process of community development (Ledwith 2011:2; Pawar 2014:91) in

which the community itself determines the process of development, sets priorities and is in control of structures and decision making (Ife 2013:174). The process of community development should be owned by the community, although the part of “discovering and mobilizing the resources and strengths, or assets” (Kretzmann, McKnight, Dobrowolski & Puntenney 2005:31) might need the assistance of an enabler … a possible role for an NGO (De Beer & Swanepoel 2011:38).

White (1996:7f) describes four levels of participation: nominal, instrumental, representative and transformative. In the nominal form, participation has mainly a formal sense. The instrumental form requires people’s participation, for example: locals are obliged by the NGO to provide materials or work time to build a school whereas in the representative form of participation people may share their opinion and their own interests. The transformative form of participation raises people’s consciousness and confidence in their ability to make a difference through practical experiences.

In general, the tendency of participation levels to decline over time has to be taken into account (White 1996:11). Understanding its manifold dimensions helps to keep up the level of participation (Rahnema 2010:138). Ife (2013:173f) observed under what conditions people are most likely to participate. Firstly, active participation acknowledges the diverse skills, roles, interests and talents of the community members (Ife 2013:174) and

> […] will legitimise equally all people who are actively involved (Ife 2013:292).

Furthermore, people participate when they experience the value and importance of their activity; when they get the feeling of making a difference; when participation is being enabled and supported; and when processes and structures are inclusive and known (Ife 2013:173f). That inclusive process is time-consuming and cannot be achieved quickly (Ife 2013:172). Moreover, conflicts should be expected because the voiceless gain a voice that challenges existing power structures and relations (White 1996:15).

Rahnema (2014:142) summarises the participatory ideal with qualities such as

> […] attention, sensitivity, goodness or compassion, and supported by such regenerative acts as learning, relating and listening, […] which always help flower, in others, their potentialities of inner transformation (Rahnema 2010:142).

The headword of "inner transformation" leads to another central element of community development: empowerment.

2.3.2 Empowerment

De Beer and Swanepoel (2011:51) emphasise that "participation can only be meaningful if it goes with empowerment", though empowerment is being defined in multiple ways. According to Jupp and Ibn Ali, it has to be taken into account that

> […] the term has different connotations in different socio-cultural and political contexts and is shaped by beliefs and value systems (Jupp & Ibn Ali 2010:29).

Alsop (2007:120) describes empowerment as "enhancing an individual's or group's capacity to make purposive choice and transform that choice into desired outcomes". Ife describes his understanding of what empowerment means as

> […] providing people with the resources, opportunities, vocabulary, knowledge and skills to increase their capacity to determine their own future, and to participate in and affect the life of their community (Ife 2013:277).

In other words, "empowerment aims to increase the power of the disadvantaged" (Ife 2013:63). As the most commonly discussed dimensions of disadvantage, Ife (2013:70) names class, gender and race/ethnicity. Friedmann uses the term "disempowered people" for the disadvantaged (Friedmann 1996:167) and describes them as

> […] households that are at war internally, or that have broken with family and friends, or that are shunned by neighbours, or that fail to take part in community organisations (Friedmann 1996:165).

He also describes them as people, who "lack job security" and "become dependent on charity and welfare, their lives controlled by social workers and bureaucrats" (Friedmann 1996:167). In fact, creating dependency is the opposite of empowerment (De Beer and Swanepoel 2011:55). Development and empowerment is not about improving people's situation as welfare programs aim to do, it is rather about focusing on the whole person and on a total transformation of his/her condition of life (De Beer & Swanepoel 2011:55). This means empowerment is, as it is participation, a time-consuming process as

well as an outcome (Parpart 2014:410). Jupp and Ibn Ali emphasise though, that because of its

> […] complex, interrelated elements embracing values, knowledge, behaviour and relationships […] the empowerment process is non-linear (Jupp & Ibn Ali 2010:16).

The context changes constantly and "the idea of what it means to be empowered will constantly shift" (Jupp & Ibn Ali 2010:39). This complex nature of empowerment makes its measurement elusive (Parpart 2014:410). Nonetheless, Alsop (2007:123) names three direct measures for tracking empowerment:

- *existence of choice* (Does an opportunity to make a choice exist?)
- *use of choice* (Does a person or a group use the opportunity to choose?)
- *achievement of choice* (Does the choice result in desired outcomes?)

As mentioned above, enhancing the "capacity to make purposive choice" (Alsop 2007:120) is, according to Alsop, the heart of empowerment and therefore "choice" is central in her understanding as well as in evaluating the empowerment process and outcome. Ife, however, emphasises the aspect of "power", thus he describes seven dimensions of power that ought to be part of the empowerment process (Ife 2013:70f):

1. *Power to make personal choices and determine life chances* ("One of the major consequences of poverty is that people have little choice or power to make decisions about their own lives" (Ife 2013:70).)
2. *Power to define need* ("Needs are often determined and defined not by the person who is supposedly experiencing them […]. Need definition also requires relevant knowledge and expertise, such an empowerment process requires education and access to information" (Ife 2013:70).)
3. *Power to think* ("An empowerment process should incorporate the power to think autonomously and not have one's world view dictated either by force or by being denied access to alternative frames of reference" (Ife 2013:71).)
4. *Power to address institutions* ("A good deal of disempowerment comes from the effect of social institutions, such as the education system, the health system, the family, the church or other religious institutions, the social welfare system, corporations, government structures and the me-

dia. […] An empowerment strategy would aim to increase people's power to address these institutions and their effects, by equipping people to use them, to influence them, and to change them to make them more accessible, responsive and accountable to all people, not just the powerful" (Ife 2013:71).)

5. *Power to access and utilise resources* (for example: financial resources and non-monetary resources such as education, opportunities for personal growth, recreation and cultural experience (Ife 2013:72))
6. *Power to engage with the economy* ("An empowerment process would seek to ensure that the power of economic activity (production, distribution, exchange) was more evenly distributed" (Ife 2013:72).)
7. *Power to control reproduction* ("[…] not only processes of birth and child-rearing but also education and socialisation: the mechanisms by which the social, economic and political order is reproduced in succeeding generations" (Ife 2013:72.))

As mentioned above, empowerment is multi-layered and concerns different areas of life. Thus, facilitating its process needs action on different levels. Firstly, addressing institutions and developing structures for a more equitable access to resources and services is important (Ife 2013:71). Pawar (2014:44f) emphasises that building community networks and bonds means enhancing a community's social capital which creates opportunities for participating in the life of the community (Ife 2013:71) or as Mathie and Cunningham (2002:4) put it, social assets, such as the gifts and talents of individuals and the social relationships, fuel local associations and informal networks that unite community members' voices.

Secondly, political and social action (Ife 2013:72) against oppressive cultural, national, and community structures facilitate the empowerment process (Parpart 2014:408). These could be formal institutions (for example: a country's legal framework) or informal social rules (for example: in a society women's disempowerment may be seen as proper) that need to be addressed through social or political action (Alsop 2007:122).

Lastly, education and consciousness-raising shall help "people to understand the society and the structures of oppression" and give "people the vocabulary and the skills to work towards effective change" (Ife 2013:72). In other words, addressing the "differences in capabilities that deny actors the capacity to make transforming choices" (Alsop 2007:123) is an important part of the empowerment process. If people are not aware of these differences and do not have the capacity to make choices, education and consciousness-raising can lay the foundation for understanding. Furthermore, skills and capabilities for action need to be developed. Awareness raising and capacity building (Ife (2013:72) prefers the terms *education* or *equipping people*[6]) go hand in hand and result in empowerment (Pawar 2014:108).

> Empowerment involves a form of critical education that encourages people to question their reality: this is the basis of collective action and is built on principles of participatory democracy (Ledwith 2011:3).

According to Ife, the process of consciousness-raising has many forms and does not happen in a formal way, but it "seeks any opportunity to engage in dialogue and to explore paths towards collective understanding, shared experience and action" (Ife 2013:167). Consciousness- or awareness-raising is about developing people's faith in themselves and to transform despair to hope and dependence to independence (Pawar 2014:109; Freire 1972:75-118). Hence two-way, eye-to-eye, equal-level communication and dialogue that values, explores and reflects critically each other's understanding of the world leads to action (Pawar 2014:109).

Most communities are aware of their needs and deficiencies. Asset-based community development acknowledges these needs, but seeks to raise people's awareness of their resources and of seeing themselves not as victims of circumstances, but as active agents that can change their environment (De Beer & Swanepoel 2011:47). Thus, education, both formal

[6] Ife (2013:24) challenges this by arguing that using the term "capacity building" implies that the community lacks something ("capacity"), hence it is not appropriate to use "capacity building" in an asset-based approach. He prefers to use the terms *education* and *equipping people* (Ife 2013:72). He also sees the term "social capital" as problematic. Although it is often used when it comes to asset-based approaches, Ife (2013:24) states, that the term is adopted from the neo-liberal language and cannot be freed of the corresponding implications ("*Neo-liberalism accepts inequality as both necessary and desirable, if economic growth and individual prosperity are to be maximised*." *"[…] an extreme form of unregulated capitalism […]*" (Ife 2013:10).)

and informal, on culture, economy, political systems, ecology, health and so on should be the goal as foundation of empowerment (Pawar 2014:31).

2.3.3 Methods of ABCD

A variety of methods are used in the ABCD approach. It is a community's situation that determines the best way to work out its future path. All of the varying methods used within ABCD have a common focus on a community's strengths and successes as an initial step for change (Mathie & Cunningham 2002:6). The following elaboration does not intend to give a complete overview of methods, rather it is meant to give some examples of how diverse ABCD is in practice. The first two tools described are in practice for localising the assets and potentials of a community and the following two methods are in practice for mobilizing the identified assets of a community.

Asset Mapping

According to Kretzmann and McKnight (1993:5), effective community development efforts are based on an understanding, also called a "map", of the community's assets, capacities and abilities. The key is to locate the available local assets, and Asset Mapping is a visualising tool for it (Kretzmann & McKnight 1993:6). The inventory (household by household, building by building, block by block (Kretzmann & McKnight 1993:6)) begins with the individual gifts, abilities and capacities of the community's residents, followed by citizen's associations and then formal institutions that are located in the community (Kretzmann & McKnight 1993:6). These three major categories are the asset base of every community (Kretzmann & McKnight 1993:8) and having them depicted in a map enables the community to recognise how to build on them.

Capacity Inventory

Asset Mapping provides a method for visualising the community's assets in a broad manner (including citizen's associations and formal institutions), whereas Capacity Inventory is meant to be a tool for "identifying what local citizens can contribute to community-building" (Kretzmann & McKnight 1993:14). Alt-

hough the questions can be adapted for each group, four parts are predominant in a Capacity Inventory (Kretzmann & McKnight 1993:14):

- Skills Information: In this section, the questions concern the individual skills of a person, whether learned at home, in the community or at their workplace. It is also asked whether and how someone is willing to contribute to the community (Kretzmann & McKnight 1993:14).
- Community Skills: This part of the questionnaire or interview is about the kinds of community work a person has participated in and is willing to do in the future (Kretzmann & McKnight 1993:15).
- Enterprising Interests and Experience: The questions here are about willingness to start a new business (sale of any goods or services) and about what kind of business activity people are interested in. It is also asked whether and what possible barriers the person has that prevents starting the business (Kretzmann & McKnight 1993:15;16).
- Personal Information: This information is used for the follow-up.

The aim of the Capacity Inventory is both to develop people's capacity and to link community members with other community members or with community organisations (for example: local associations, local businesses, etc.). For such purpose, the information collected through interviews or questionnaires, has to be transmitted. These connections are established so that community members can contribute with their skills and abilities and thus strengthen their own community (Kretzmann & McKnight 1993:17).

Appreciative Inquiry

Appreciative Inquiry (AI) seeks to identify that which is already creating life and value in a community, elaborates on what is working and generating well-being, and asks what made social organisation possible (Myers 2011:258). Starting from such perspective, rather than asking problem focused questions, helps the community members to see themselves as capable, because they realise that they have achieved things in the past and that they do have resources (Myers 2011:263). Such positive mind-set is basis for developing "a realistic and realisable vision for the future and a commitment to take sustain-

able action" (IDeA 2010:26). AI is not only applicable to communities, but to all kinds of groups and to organisations as well (IDeA 2010:26).

AI is based on "principles", "assumptions" and "processes" (Reed 2007:26). Reed (2007:27f) identifies the following as the underlying assumptions of AI, as well as the basis for the facilitator's attitude and mind-set:

- "In every society, organisation or group, something works."
- "What we focus on becomes our reality" (creates a sense of possibility rather than limitations).
- "Reality is created in the moment, and there are multiple realities" (people experience the same situation differently).
- "The act of asking questions about an organisation or group influences the group in some way" (asking questions stimulates reflection).
- "People have more confidence and comfort to journey to the future (the unknown) when they carry forward parts of the past (the known)" (it should be the best parts of the past).
- "It is important to value differences" (not seeking the consensus but appreciating different perspectives).
- "The language we use creates our reality."

Letting participants tell stories of "peaks" in their successes, positive experiences, and lessons from the past are core parts of an AI (Reed 2007:26). Appreciating the best of what is and looking at strengths has an impact beyond the exercise itself (Reed 2007:39). Discovering what gives energy and life, what works, and what can be built upon is the foundation of further processes (Reed 2007:32; IDeA 2010:26). The interviewer then has to go "beyond the past to envision the best possibilities of the future" (Reed 2007:26). Finally, the participants think about specific activities, actions, and their commitment to them (Reed 2007:33) as well as how the group can ensure sustainability of these changes (IDeA 2010:26).

The main critique of AI is that it is naïve, idealistic and ignores negative experiences. Practice shows, however, that discussing difficulties in an appreciative context leads often to a more open attitude and higher participation (Reed

2007:39; Myers 2011:261). From a theoretical perspective, the constructivist approach has been criticised because AI does not seek the objective facts as such, but wants to explore the way people construct their world socially (Reed 2007:40). Not rejecting people's personal experiences "reaffirms their worth, ability, and potential" (Reed 2007:28), in other words it empowers the participants and enables them to positively shape their future.

Participatory Learning and Action

Participatory Rural Appraisal (PRA) emerged in the 1990s as a further development of the Rapid Rural Appraisal (RRA) which developed in the 1980s (Chambers 2009:103; 1994:953; Myers 2011:255). PRA has also been used in urban settings or refugee work, which is why the name changed over time to "Participatory Learning and Action (PLA)" (Myers 2011:255). PLA is a set of tools and methods to enable local people "to share, enhance and analyse their knowledge of life and conditions, and to plan, act, monitor and evaluate" (Chambers 2009:102). According to Myers (2011:256), it is often an eye-opener to people and communities about what resources and skills they already have.

An important principle of PLA is that outsiders facilitate, listen, and learn, but they do not transfer technology or dominate the process. It is crucial that the participants express their own reality (Chambers 2009:103), assuming that the facilitator recognises the community as a heterogeneous group with many perspectives that have to be taken into account (IDeA 2010:28).

Chambers lists examples of methods of PRA/PLA that can be combined in different ways (Chambers 2009:136) and that support local people in analysing their own reality:

> […] mapping or modelling on the ground or paper; listing, sequencing and card sorting; estimating, comparing, scoring and ranking with seeds, stones, sticks or shapes; Venn diagramming; linkage diagramming; and group and community presentations for checking and validation (Chambers 2009:116).

Chambers (2007:26) emphasises that "critical self-awareness is part of learning and developing, and one key to facilitation". The facilitator should further be humble, ready to listen patiently and with interest what people have to say.

Believing in the people who participate and transmitting that confidence empowers them to take action (Chambers 2009:134).

2.4 The Care Group model

As mentioned in section 2.2, the aim of human development interventions is the improvement of people's living conditions that culminates in strengthening the individual's self-responsibility and opportunities for participation (Sangmeister & Schoenstedt 2009:147). Pawar (2014:31) adds and emphasises the importance of health and educational dimensions when it comes to the development of human resources. All other dimensions depend on healthy people and communities and therefore disease prevention approaches and promotion of good health practices are crucial as solid basis for strengthened communities (Pawar 2014:31). This is what the CG model, described in the following sections, seeks: to achieve strengthened communities through health promotion (World Relief 2004:5).

2.4.1 Origin and focus of the CG model

The CG model, a development method, has been initiated by the NGO World Relief in the 1990s as a community-based health care approach in a development setting in Mozambique (World Relief 2004:5). Dr Pieter Ernst, a physician, developed the CG model in order to reach a large population with health messages in a cost-efficient and sustainable way. The aim was to finally see healthier communities after 17 years of civil war in Mozambique (World Relief 2004:5). To this end, he initiated a vast network of volunteers to reach as many households as possible, without making the responsibilities of the volunteers too burdensome (World Relief 2004:5). The success of the CG model in Mozambique led World Relief to apply it to many other Child Survival Projects in varying contexts (World Relief 2004:5). Although the interventions (for example: Child Survival Project, HIV/AIDS prevention and care, Food Security Project) and the context may differ, the core elements of the CG model (volunteer effort, peer support and community mobilization) remain the same (World Relief 2004:6).

2.4.2 Method of the CG model

A Care Group (CG) is a group of ten to fifteen volunteers who serve the community as community-based health educators. In regular meetings with the NGO staff (also called promoters) the volunteers receive training, supervision and support. Each volunteer is responsible for ten to fifteen neighbour households and visits them individually on a biweekly basis in order to share the lessons learnt about health practices (World Relief & Food for the Hungry 2010; World Relief 2004:7). The structure of the CG model is shown below in figure 2.1.

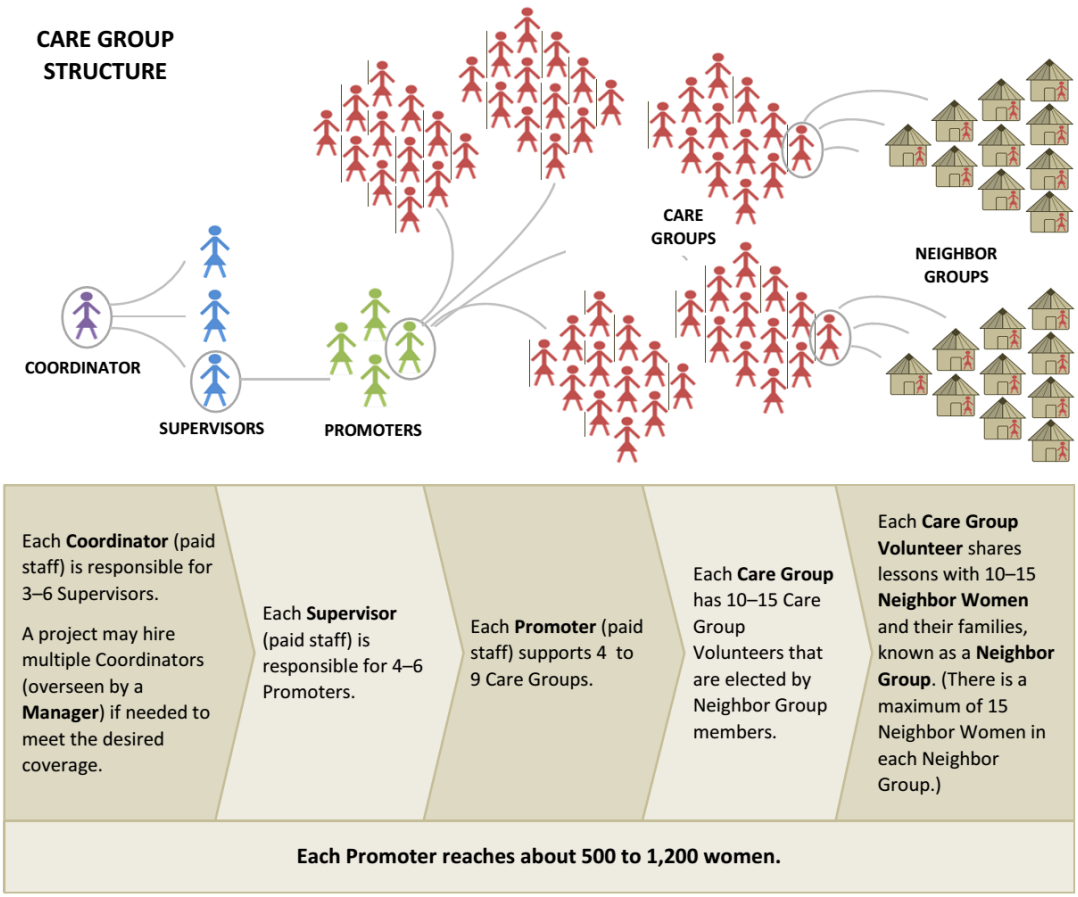

FIGURE 2.1: THE CARE GROUP STRUCTURE
(Source: FSN Network 2014:16)

The CG volunteers are part of the community and elected by the community (World Relief & Food for the Hungry 2010) and therefore they are respected persons who know the local culture, values, history, etc. The sharing of knowledge gained with the group empowers both the volunteer herself, be-

cause she receives training and, at the same time, she acts as a catalyst for empowering her neighbours and for behaviour change (World Relief 2004:8).

The CG volunteer's commitment has a multiplier effect (World Relief 2004:5f) and the resulting improved health behaviour builds resilience in the community, for example: mothers know better how to feed their children in a crisis affecting food security or have a better understanding of basic hygiene principles. Key aspects in ensuring behaviour change have been identified: participation, peer learning and the supportive environment in CGs (CORE Group 2014:9). These are at the same time basic principles of Community Development approaches (De Beer 2015:45). Through peer-to-peer learning among the participants of CGs (WR & FH 2010), training and motivation come from within the group

> […] on the basis of what people *are*, what they *know*, how they *live*, what they *do*, what they *know how to do* and what they *want* (Ekins 1992:114).

The community members' social relationships and the voluntary commitment are examples for assets of a community (Haines 2009:40f; Raniga 2014:75f; Kretzmann 2010:486f). CGs achieve broad, deep and lasting community change (World Relief 2004:1) by effectively mobilizing community and religious leaders as well as established structures (World Relief 2004:8; 27). Furthermore, CGs strengthen, equip and link communities and civil society organisations on grassroots level (World Relief 2004:18 and 49).

CGs also provide the structure for a community health information system that reports on, for example: new pregnancies, births and deaths detected during home visits (Core Group et al 2014:2).

Care Group Criteria

There are many development projects that work with different kinds of groups (for example: mother's groups, saving groups) and they sometimes used the term "Care Groups", although they did not always follow the original design of the CG model. World Relief and Food for the Hungry, therefore, developed a list of criteria for CGs. It contains 13 required criteria when using the term "Care Groups" and four suggestions (World Relief & Food for the Hungry 2010:1). Required criteria for CGs are:

1. CG volunteers should be chosen by the participants within the group of households that they will serve, or by the village's leadership, but not by program staff.
2. The workload of CG volunteers should be limited to no more than 15 households per CG volunteer.
3. The CG's size is limited to 16 members, which allows participatory learning. Attendance is monitored for identifying signs of problems as early as possible.
4. CG volunteer contact with the households she/he is responsible for at least once a month. The CG meeting frequency is at least once a month (preferably twice monthly; meeting frequency correlates with behaviour change) and it is monitored.
5. The plan is to reach 100% of households in the targeted group at least monthly, and the project attains at least 80% monthly coverage of targeted households, which is monitored.
6. CG volunteers collect vital events data on pregnancies, births, and deaths. Recording and discussing the collected data in CG meetings allows volunteers to draw connections between their work and the health events in their community.
7. The majority of what is promoted through the CG creates behaviour change directed towards reduction of mortality and malnutrition (This criterion was established for advocacy purposes of the effectiveness of CGs in reducing child and maternal mortality and malnutrition. The structure of CGs can then be adapted for other settings and topics with a different name).
8. The CG volunteers use some sort of visual teaching tool, such as flipcharts, to do health promotion at the household level.
9. Participatory methods of behaviour change communication (BCC) are used in the CG, as they are more effective in teaching adults.
10. The CG instructional time (when a Promoter teaches CG volunteers) is no more than two hours per meeting.
11. Supervision of Promoters and at least one of the CG volunteers occurs at least monthly to receive feedback and support.

12. All of a CG volunteer's visited households should be within a distance that facilitates frequent home visitation (~ 45 minute walk). All CG volunteers should live less than an hour walk from the location of CG training.
13. The project/program culture should convey respect for the population and the CG volunteers, and foster their empowerment, especially of women (World Relief & Food for the Hungry 2010:2f; IMC 2015:6f).

Suggested criteria for Care Groups are as following:

1. Formative research should be conducted, especially on key behaviours promoted.
2. The Promoter-Care Group ratio should be no more than 1:9, which translates approximately to 150 volunteers with which they work.
3. Measurement of many of the results-level indicators should be conducted annually at a minimum.
4. Social/educational differences between the Promoter and CG volunteer should not be too extreme: for example: having bachelor degree level staff working with illiterate CG volunteers (World Relief & Food for the Hungry 2010:4).

Resilience as an effect of the CG model

As mentioned above, CGs contribute to build resilience of a community. Especially in times of crisis, community-based human services (for example: health, education, housing, law and order, care for dependent people) rely on the resources, capacity and expertise of the local community (Ife 2013:125). In other terms, the community's sustainability and its resilience make a difference when it comes to difficult times. Katherine Pasteur gives an overall definition of resilience as

> […] the capacity to endure shocks and stresses and bounce back; individuals or communities that can ride out the difficulties that life might bring without their overall situation deteriorating (Pasteur 2011:13).

That capacity applies not only to short-term occurrences. Individuals and communities are often confronted with long-term negative trends that require the ability to improve their lives despite the circumstances (Pasteur 2011:13).

The European Commission defines resilience in the same way and states, additionally, that it cannot be seen as an

> […] isolated objective but as an integral part of the poverty reduction and lifesaving aims (European Commission 2013:3).

In other words, poverty, vulnerability and disasters are closely linked. Effective ways need to be found to address the multiple underlying factors of a community's vulnerability such as lack of resources, fragile livelihoods, exposure to hazards, climate change and other trends, and weak institutional support mechanisms (Pasteur 2011:3;4).

The study of the International Federation of Red Cross and Red Crescent Societies crystallizes six main points as characteristics of a resilient community, as shown in the table 2.1.

TABLE 2.1: CHARACTERISTICS OF A RESILIENT COMMUNITY

A safe and resilient community …	… is knowledgeable and healthy (for example: can learn new skills).
	… is organised (for example: has the capacity to identify problems and act).
	… is connected (for example: has relationships with external actors).
	… has infrastructure and services (for example: housing, water, sanitation systems).
	… has economic opportunities (for example: employment opportunities and financial services).
	… can manage its natural assets.

(Source: IFRC 2012b:iv)

It is also stated that resilience should be seen as an on-going process involving multiple actors, rather than an outcome, i.e. a community's context is too complex; thus, its resilience can never be completely achieved (IFRC 2012b:11). Nevertheless, the empowerment process strengthens the community's resilience. This is equally important for communities in a development setting as well as in humanitarian initiatives.

2.5 Development and Humanitarian action

This research focuses on the interventions of the humanitarian NGO Medair[7], using the CG model as a development method. An introduction of humanitarian action shall therefore be given in this section, later followed by a discussion about linking relief work and development interventions.

[7] More about Medair in section 3.3.

2.5.1 Principles of Humanitarian Action

Alleviating the suffering of others is a centuries old motivation for action. But the origins of the international humanitarian system can be dated back to 1859 (Hilhorst 2013:6) and located in the European experience of war and natural disaster (Davey, Borton & Foley 2013:1). The creation of the International Committee of the Red Cross (ICRC) 1863 was a consequence of a series of humanitarian initiatives at this time (Davey, Borton & Foley 2013:5). According to Lieser and Dijkzeul (2013:1;2), humanitarian action is still considered a minor part of international cooperation, particularly in the German speaking contexts.

A clear definition of humanitarian action cannot be found; however, human needs are focused on in all humanitarian activities. The operations cover a wide spectrum, for example: “responding to needs in situations of conflict or natural disasters, supporting displaced populations in acute and protracted crises, risk reduction and preparedness, early recovery, livelihoods support, conflict resolution and peace-building” (Davey, Borton & Foley 2013:1).

Undoubtedly there are similarities and overlap between development work and humanitarian aid. Humanitarian assistance, however, faces different challenges to development cooperation and therefore requires a different logic of action. In general, humanitarian interventions take place in complex situations influenced by conflicts, a difficult political and social environment and under high expectations and time pressure. In comparison to development work, of which the key elements are, for example: self-reliance, capacity building, sustainability, and as shown in table 2.2, principles like humanity, neutrality and independence are basic in humanitarian actions (Lieser & Dijkzeul 2013:10).

TABLE 2.2: HUMANITARIAN VERSUS DEVELOPMENT PRINCIPLES

Humanitarian principles	Development principles
Humanity Impartiality Neutrality Independence Universality	Empowerment Participation Sustainability Self-reliance Equity Capacity building Transparency/accountability

(Source: FAO & WFP 2010:17)

Not only saving lives, alleviating suffering, upholding human dignity, but also building resilience is a core task of humanitarian assistance.

> Those in need are not passive recipients of aid, solely defined by their victim-hood. They are active participants in the process, often the first responders in cases of natural disaster and vocal supporters or detractors of externally led policies (Peterson 2015:2).

Peterson (2015:2) requests to hear and understand their voices in order to integrate them into the debates on humanitarian work. Mathbor and Bourassa (2012:305) agree and state that humanitarian aid that works with participatory methods enhances the community's capacity.

It is incontestable that humanitarian aid saves many lives and relieves suffering worldwide; however, humanitarian action and development interventions still come mainly from the global North (Slim 2015:13) but operate in countries of the global South. It is therefore appropriate to listen to criticism on which to reflect seriously. Based on Esteva (2010:2), one of the possible underlying difficulties of Western development intervention in the global South is the wording that implies a certain worldview. Former U.S. President Harry S. Truman (1945-1953) left his mark on the expression "underdevelopment" which became a common concept in development cooperation (Esteva 2010:2). Someone's identity is defined through someone else's lenses of reality (Esteva 2010:2) and this attitude leads to "welfare and betterment programmes" (De Beer & Swanepoel 2011:55) rather than development interventions. De Beer and Swanepoel (2011:55) describe unequal power-relations between receiver and giver, and increasing dependency of people as the negative consequences of welfare interventions.

Although in many cases humanitarian agencies are not failing morally, but are "simply overwhelmed by anti-humanitarian power" (Slim 2015:15), Slim (2015:20) lists three main critiques. Firstly, there is "neo-colonialism" (Slim 2015:20), that is linked to the often-visible wealth of western NGOs ("fancy offices and endless white Toyotas" (Slim 2015:20) and in some cases its excessive political influence in post-colonial states (Slim 2015:20;21). Secondly, Slim adds that humanitarian aid has been instrumentalised for political and even military purposes (Slim 2015:21;22) and lastly, that humanitarian action is sometimes seen as interfering or delaying necessary political changes (Slim 2015:23). De Beer and Swanepoel (2011:55) recommend analysing critically "so-called development efforts" of development agencies and community development workers, which can be extended to humanitarian organisations. "Relief and improvement will not free people" (De Beer & Swanepoel 2011:55) because it addresses only the symptoms and does not change the status quo.

2.5.2 Complex emergency, protracted crisis, chronic conflict

According to the report "The State of Food Insecurity in the World 2015", today's crises are in general more complex and protracted than 30 years ago, and short-term emergencies have become an exception. The combination of multiple factors, mainly natural disasters, conflicts, climate change and financial crises, leads to these more structural, longer-term and protracted situations, also called complex emergencies or chronic conflict (FAO, IFAD & WFP 2015:38). The Humanitarian Policy Group at the Overseas Development Institute (ODI) defines a protracted crisis as a persistent situation of political instability and military conflicts combined with socio-economic conditions that imperil the lives and livelihoods of a significant portion of the population (Jones 2004:15). The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) states that "the majority of today's humanitarian crises are protracted in nature" (OCHA 2015b:3) and are accentuated by the fact that "the average duration of a humanitarian appeal is now seven years" (OCHA 2015b:3). Alinovi *et al* (2008:2) emphasise that protracted crises are difficult to analyse due to lack of adequate information and complexity of the situation as well as the danger and the logistical problems that usually co-occur and com-

plicate “adequate response options on the part of the international community as well as the aid organisations” (VENRO 2006:4).

Although the crises are diverse, severe malnutrition and food insecurity are in most cases the consequences of its long duration (FAO, IFAD & WFP 2015:37). The displacement of people due to an armed conflict has a negative impact on the resources of a community and its livelihood opportunities (FAO 2016:8). It causes long-lasting, multi-generational negative impacts on a society due to the malnourishment of its children. If children have no access to nutritious food during a certain phase of their development, mental and physical handicaps can be the consequences (FAO 2016:2).

> The proportion of undernourished people is almost three times as high in countries in conflict and protracted crisis than in other developing countries. Approximately 167 million undernourished people live in countries in protracted crisis today […] (FAO 2016:2).

As shown in figure 2.2, South Sudan and Somalia both struggle with huge numbers of internally displaced people (IDP) and food insecurity is the reality of millions of inhabitants of these two countries. Both countries suffer from protracted crises.

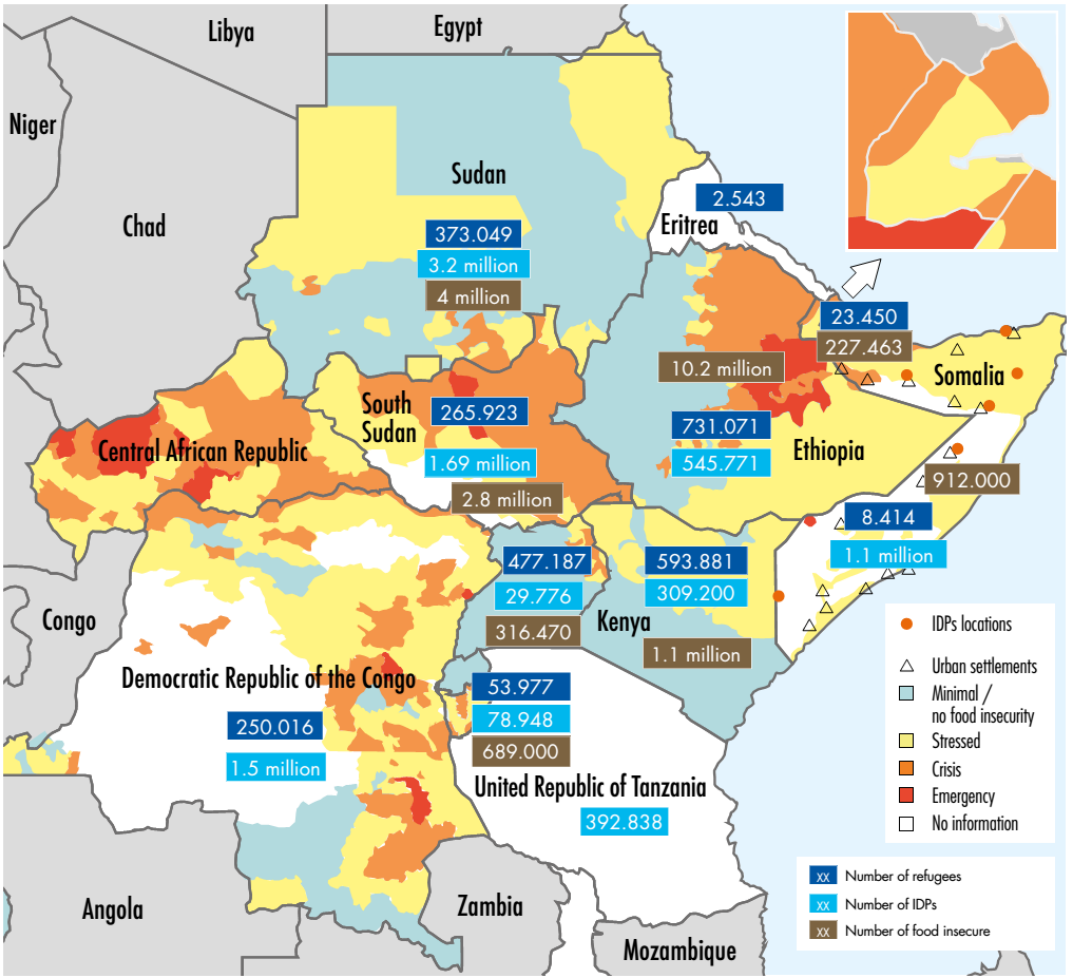

FIGURE 2.2: FOOD INSECURITY AND DISPLACEMENT IN THE REGION, FEBRUARY 2016
(Source: FAO 2016:11)

2.5.3 Linking Relief Rehabilitation and Development (LRRD)

In case of a catastrophe, the ideal transition is from relief to rehabilitation and then to development cooperation. A relief phase lasts generally a couple of weeks up to several months. The primary goal is to secure the survival of those affected. Rehabilitation often sets in while relief is still in progress and covers a period of one to several years followed by development cooperation. Aims of the latter are already part of the rehabilitation phase, but planning and building partnerships with local organisations determine rehabilitation. In case of a chronic crisis, the relief phase lasts longer than a couple of weeks (VEN-RO 2006:3).

World Food Program's (WFP) forecast is that within 13 years "two-thirds of the world's poor will live in nations classified as fragile" (WFP et al 2016:2). If

considered that “conflicts can reverse hard-won development gains by more than 20 years” then Linking Relief, Rehabilitation and Development (LRRD) becomes crucial (WFP et al 2016:11), especially in protracted crises that are interrelated with political instability and military conflicts (Jones 2004:15).

LRRD is a widely researched and discussed topic. The concept originated in the 1980s and was formulated by the Commission of the European Communities in 1996 and 2001. The aim was to integrate long-term development issues in short-term relief mechanisms and to strengthen coping strategies and disaster preparedness through adapted development policies (Commission of the European Communities 2001:3). The object of LRRD is to combine the strengths of humanitarian action and development cooperation. The World Food Program declared recently:

> Development can no longer be divided from humanitarian action. Better risk management and strengthened resilience are as central to development as they are to humanitarian response (WFP 2015:6).

This is particularly true for countries affected by protracted crises like South Sudan and Somalia that are the context of the case study (see chapter 3).

Development orientation of Humanitarian Action

Humanitarian assistance focused on the immediate need to save lives is critical in protracted crises – as it is in shorter-duration emergencies – but in protracted crises it is also essential to direct assistance towards underlying drivers and longer-term impacts (FAO & WFP 2010:4). These circumstances have a significant influence on the work of aid agencies. On their part, LRRD requires a shift towards more long-term commitments and with that a change in the mind-set among aid staff and policy-makers (van Dijkhorst 2013:242).

Goetze (1999:33) explains that the relief-development continuum works in insidious natural disasters (for example: droughts) in fairly stable societies with functioning state authorities as well as intact social structures on which relief organisations can rely. This is not the case in complex emergencies in which state and social structures are often poorly available and humanitarian organisations face difficulties in accessing the affected people (Goetze 1999:34).

LRRD is not easily put into practice. In Somalia, for example, aid organisations were strongly confronted with conceptual and operative challenges because of “the parallelism of relief, rehabilitation and development cooperation” (VENRO 2006:4). As a “parallelism”, the situation was described when in some hardly accessible areas of Somalia food was still distributed among refugees, whereas the same organisation provided agricultural services in other regions of the country (VENRO 2006:4). Another tension may occur when interests of relief and development cooperation differ:

> […] for example: if there is a threat of famine and food aid has to be provided from outside from a humanitarian angle while from a development angle the local markets must not be destroyed through food imports (VENRO 2006:2).

The implementation of LRRD may not always be successful, sometimes because the context of action changes rapidly, or other difficulties may come up, or humanitarian as well as development NGOs have to rethink their action plans; however, for the sake of crisis affected people and their future LRRD should be the aim of NGO’s (VENRO 2006:6). VENRO (2006:6) lists a number of LRRD objectives, a selection of them shall be mentioned here:

- The program/project not only restores the status quo, but aims to achieve sustainable and qualitative improvements in the living conditions of those affected.
- If not a single organisation can implement all phases of a project, cooperation with other NGOs is sought.
- The people affected are involved right from the beginning.
- Aid is provided via a local partner organisation if possible.
- Projects do not offer isolated support (for example: reconstruction of housing), but follow an integrated approach.

In case of a crisis, the link between development assistance and relief work is crucial for the future of the affected community as is its ability to react to stress. Internally displaced or refugee women and children are the most vulnerable, especially during recovery stage (Mathbor & Bourassa 2012:306). It is stated by UNISDR, however, that the exposure to risks and hazards of persons and assets at community level “in all countries has increased faster than vulnerability has decreased” (UNISDR 2015:10). Disaster prevention and risk

reduction are therefore an integral part of LRRD (VENRO 2006:5;8) and contribute to sustainable development (UNISDR 2015:9).

Disaster Risk Reduction (DRR)

La Trobe and Davis (2005:1) describe DRR as "technical, social or economic actions or measures used to reduce direct, indirect and intangible disaster losses". DRR seeks to mitigate "the destructive and disruptive effects of hazards", as well as ensure

> […] the readiness and ability of a society to forecast and take precautionary measures in advance of imminent threat, and respond and cope with the effects of a disaster (La Trobe & Davis 2005:1).

The rehabilitation phase after a disaster has been proven as the critical opportunity for taking measures for disaster risk reduction practices (UNISDR 2015:21), which shall be "multi-hazard and multi-sectoral, inclusive and accessible in order to be efficient and effective" (UNISDR 2015:10). The *Sendai Framework for Disaster Risk Reduction 2015-2030*, "supported by the United Nations Office for Disaster Risk Reduction" (UNISDR 2015:5), defines four priorities for action that contribute to put DRR into practice in projects and programs (UNISDR 2015:36):

1. Understanding disaster risk;
2. Strengthening disaster risk governance to manage disaster risk;
3. Investing in disaster risk reduction for resilience;
4. Enhancing disaster preparedness for effective response, and to «Build Back Better» in recovery, rehabilitation and reconstruction.

DRR is a process and its implementation takes time (La Trobe & Davis 2005:9); however, it "reduces emergency response time and costs, saving lives and maximizing the use of the limited financial resources available" (WFP et al 2016:15), and is therefore an important aspect of LRRD (WFP et al 2016:24).

2.5.4 Care Groups in relief settings

According to the evaluation *Care Groups in Emergencies*, conducted by the International Medical Corps (IMC), CGs "have played an important role in addressing health and malnutrition in development contexts" (IMC 2015:23); however, they are expanding into other sectors as well as into emergency

settings (IMC 2015:5). The CG's possible impact in relief settings are therefore being explored and necessary adaptations made for challenges that could occur, because "emergencies are complex situations with multiple variables" (IMC 2015:5). 'Emergency setting' refers in the evaluation either to refugee or internally displaced people (IDPs) camps or to communities where people reside permanently or temporarily (IMC 2015:8).

Summarizing the overall recommendations, IMC does not recommend initiating CG in acute emergencies although when CGs already exist their structure can be used for emergency messaging. In the transition from either emergency to development or vice versa CGs have successfully been used. The same applies to the implementation of CGs in protracted crises, because of usually longer-term funding and time for planning (IMC 2015:22f). A major challenge in protracted conflict situations, however, is insecurity. Interrupted programming that affected the behaviour uptake is mentioned in the evaluation as a consequence of the insecure project environment in countries such as in Somalia or South Sudan (IMC 2015:20). The population is often mobile due to conflict that hinders the implementation of CGs, but IMC recommends further research on how a mobile population could be reached with behaviour change messages (IMC 2015:21;22).

In terms of necessary adaptations, IMC compared the criteria of CGs (see 2.4.2) in development settings with implemented CGs in emergency settings. A selection of the major findings shall be given in the following paragraph.

Concerning the volunteer selection (Criterion No 1), IMC found that in some cases an election of CG volunteers was not possible due to a lack of community stability. The recommendation is that community leaders or program staff select interim CG volunteers but, once stabilized, the situation is then evaluated and elections shall be conducted (IMC 2015:12). In the case of South Sudan, Ndungu and Tanaka (2017:6) describe that it was not possible to get up-to-date lists of inhabitants from community leaders due to population transience. Thus, it was the project staff who identified CG participants and placed them in groups which prevented the exclusion of vulnerable women or women of a different ethnic group. Food for the Hungry (FH) found it possible

in the post-earthquake situation in Haiti to let the neighbourhood elect CG volunteers (Davis 2013:8).

The seizing of a CG (Criterion No 3) in emergency settings is variable, depending on the situation. If the emergency affects communities with for example: a low literacy level, the CG volunteers' literacy level would become a determining factor of the group's size. For example, explanation of the information may take more time if the participants are illiterate (IMC 2015:10). Furthermore, training and monitoring tools (Criterion No 8) have to be appropriate to the CG volunteer's literacy level (IMC 2015:13). Ndungu and Tanaka (2017:4) did not experience the literacy level of the CG volunteers but the population's movement as a determining factor of the group's size. In their project context in South Sudan, they kept the group's size small and it was not set in advance because women moved (due to flooding, insecurity or returning IDPs) and the groups wanted to have the possibility to accommodate new participants. Davis (2013:8) reports the size of the CG in the context of Haiti as about ten volunteers with each responsible for ten households.

Collecting data (Criterion No 6) may not be a priority, but, if collected, the data should be relevant to the emergency circumstances (for example: household needs, disease burden) (IMC 2015:13).

> The topics covered [Criterion No 7] in CGs in emergency settings must reflect behaviour change actions relevant to the specific emergency (IMC 2015:13).

In the case of Haiti, Davis (2013:8) mentions in the report that it was expected to cover non-health topics but the CG then concentrated on issues of water, sanitation and hygiene (WASH).

It is recommended that the meeting length (Criterion No 10) be kept flexible, especially when psychosocial support is needed (IMC 2015:12), and not only women (Criterion No 13) but the entire population affected should be addressed with emergency adapted messages (IMC 2015:11).

Research and analysis (Suggestion No 1) of whether the CG model is a context relevant method shall be conducted in development settings; however, in an unstable emergency setting the conduction of formal analyses is challenging. IMC recommends therefore, using less formal methods for emergency

contexts such as focus group interviews (IMC 2015:14). Food for the Hungry conducted a formal research study as soon as the situation stabilized (Davis 2013:11).

IMC found the same benefits of CG in emergency situations as have been documented in development settings (IMC 2015:15). Context specific benefits are mentioned, for example: the *broad coverage* of households particularly in camp settings where the people live in *close proximity*, the rapid dissemination of key lifesaving messages (IMC 2015:15), and sustainability of changed behaviour even though the environment is not stable (IMC 2015:16). Peer-to-peer learning turned out to be a crucial aspect in emergencies because social bonds are often disrupted in conflict situations, but are an important factor in how quickly a community or household recovers after a disaster. Neighbour visits are an opportunity for new social bonds, especially in the context of a refugee or IDP camp where

> […] CGs help bring together women from different ethnic, religious and country backgrounds and fosters community and bonding (IMC 2015:16).

IMC recommends conducting further research on this aspect of CGs in relief settings, especially on the effect of social bonds and psychosocial support on the receptiveness of behaviour change messages when people are in mental distress (IMC 2015:22).

2.6 Conclusion

In this chapter, the literature and topics relevant to the case study were discussed. After giving a general overview of community development, ABCD as the theoretical framework of this master' dissertation, which is a "bottom up" and "inside out" approach, was elaborated upon (Kretzmann & McKnight 1993:5). Furthermore, a selection of ABCD methods was described, for example: the appreciative inquiry as a tool to identify what is creating life in a community, what is working, and generating well-being (Myers 2011:258).

The Care Group Model, the researched model in this study, seeks to strengthen communities through prevention of health loss (World Relief 2004:5), and seeks to build on assets of the community, for example: social relationships and voluntary commitment (Haines 2009:40f; Raniga 2014:75f;

Kretzmann 2010:486f). The Care Group Model, as a development model, is being implemented in South Sudan and Somalia by the humanitarian organisation Medair[8]. The link between relief, rehabilitation and development is therefore explained as basic knowledge for the case study.

The next chapter gives an overview of the background and context of the research problem. An outline of Sudan's and Somalia's situation as the focal countries of this master's dissertation is given first, followed by the introduction of Medair as the implementing organisation of CGs in the case study.

[8] More about Medair in section 3.3.

CHAPTER THREE: BACKGROUND AND CONTEXT OF THE CASE STUDY

A major challenge for humanitarian action in countries in protracted crises is the "high or very high level of undernutrition and recurrent high level of acute malnutrition" (FAO & WFP 2010:32), which is also why Medair[9] implements the Care Group Model in Somalia and South Sudan. Some details on the context of these two countries are needed to outline the complex situation where the case study of this master's dissertation takes place. It also explains why the author most likely conducted the expert interviews via Skype and not *in situ*. The security situation for travelling in these two countries remains too unstable.

3.1 South Sudan

South Sudan is located in East-Central Africa and covers an area of 644,329 square kilometres. 15% of the country's total area comprises the world's largest wetlands. The climate is hot with seasonal rainfalls (CIA 2017).

South Sudan has a population of over 12.5 million people who belong to different tribes. Their common languages are English and Arabic. 80% of the population lives in rural area (CIA 2017).

Historical background

Even before separation into two countries, Sudan had two distinct divisions: the north where the majority of people are Muslim and the southern part where most Christians and members of indigenous faiths live. Consequential rift was intensified due to the division in administration of the two parts of the country by the British. At that time, the northerners were not allowed to enter the south (Fadlalla 2004:1).

Historically, the north was strongly influenced by Egypt. By the sixth century, Sudan had divided into three kingdoms (collectively referred to as Nubia) that adopted Christianity and had their peak in the ninth and tenth century. The Nubian people were in contact with Arabs and Muslims primarily through

[9] More about Medair in Section 3.3.

trade. Only during the sixteenth century did Islam come into the north of Sudan and for three centuries northern Nubia was ruled by the Ottoman Empire (Fadlalla 2004:1).

In the 1880s the Mahdist movement gained strength in the region, which was perceived by Britain as a threat to stability of the region. The following British intervention led to the Anglo-Egyptian condominium (Fadlalla 2004:2). From 1899 to 1956, Sudan was a British colony, although the so-called Condominium Agreement stated that Sudan belonged to Egypt. Even then the country comprised two separate entities, the North and the South (Bubenzer & Stern 2011:xv;xvi). The southern part was largely ignored by the British. Only after World War I did mission societies establish schools and medical facilities in the area (Fadlalla 2004:2).

Political situation

In 1956 Sudan became independent from Anglo-Egyptian rule, but in the year before the first civil war broke out (Bubenzer & Stern 2011:xv;xvi). It lasted 17 years and ended with the signing of the Addis Ababa Agreement in 1972 (ICG 2015:7). At that time, three provinces of the South were unified and given regional autonomy (Thomas 2015: xii).

The second Sudanese civil war began in 1981 only a nine year break after signing the Addis Ababa Agreement. Among other reasons, the attempt to control the oil fields at the north-south border as well as the imposition of Islamic law on the whole country led to repeated outbreak of war (Bubenzer & Stern 2011:xvii). War ended with the signing of the Comprehensive Peace Agreement in 2005, and an autonomous Government of South Sudan was established (Thomas 2015:xiii). More than two million people died in the two long periods of conflict between the northern and the southern part of Sudan (ICG 2015:7).

After a referendum took place and the Southerners voted for independence, the Republic of South Sudan was established in 2011 (Thomas 2015:xiii; Bubenzer & Stern 2011:xix). Despite its new autonomy, South Sudan still struggles with lack of good governance and civil war (CIA 2015). The latter started

again in December 2013 and left more than 1.6 million people displaced internally (ECHO 2015:2). Reasons for these complex and lasting conflicts are, on the one hand, the interconnections of the armed groups rooted in tangled relationships of the two countries on both sides of the border, and, on the other hand, competing individual and group interests (ICG 2015:2). Sudan has a bold diversity of ethnic groups with multiple interests and ways of life (Ryle & Willis 2012:29; Ryle 2012:70) and therefore,

> […] recurrent feuding between tribes or tribal sections is also widespread. […] In recent times, however, settlement mechanisms have been strained by the spread of firearms and the exacerbation of feuds by wider political and military conflicts (Ryle 2012:84).

Economic situation

These long years of armed conflict destroyed almost the whole crop production as well as agricultural and livestock support services, mainly due to the destruction of infrastructure and displacement of people (Pantuliano 2008:34). Agriculture was thereafter an important source of income in Sudan. Major export products were cotton, peanuts, sugarcane, sorghum, sesame and gum Arabic (Fadlalla 2004:4). The great majority of Southerners in rural areas is still dependent on agriculture as sedentary farmers or agro-pastoralists (Ryle 2012:83), which renders people "vulnerable to risks of disruption from climate and conflict" (James 2012:135). Being dependent on rainfall, the small, hand-cultivated crop production (mainly farmed by female-headed households) is highly fragile (ACAPS 2017b).

Industry in Sudan was poorly developed (Fadlalla 2004:4), but after 1990 oil became the country's dominant export commodity. The circumstances of discovering oil deposit led to a transformation of the economy; however, "reliable information on the Sudanese economy is difficult to obtain" (James 2012:135). As the oil runs out, a replacement must be found, and according to James (2012:48), agricultural projects will become more important for the country's economy than they already are. The downside is that such a transition would render the people, relying on agriculture, even more "vulnerable to risks from poor harvests, drought and falling international commodity prices" (James 2012:148).

Long-term humanitarian challenge

For decades, the Sudanese people had to move, either “seasonally for grazing, for work, or for education, unseasonally to escape war and famine” (Ryle 2012:86). Only recently, in February 2017, was famine declared in Unity state (see map below) and 4.9 million people are food insecure across South Sudan (ACAPS 2017a:1). Food insecurity is driven by conflict and the desolate economic situation of the country (ACAPS 2017a:2;5). A high level of malnutrition is the consequence. Furthermore, the people in South Sudan face limited health facilities as well as medicine shortages (ACAPS 2017a:4). Children and their education are highly affected because, for example: school buildings have been looted or are occupied either by displaced people or armed forces (ACAPS 2014:44). Almost 250,000 Sudanese refugees are living in South Sudan, as well as approximately 15,000 Congolese refugees (CIA 2017). In only the first three months of 2017, tens of thousands of people fled South Sudan for neighbour countries (ACAPS 2017a:1). Their coping strategies, for example: food reduction, selling cattle or begging, are mostly exhausted, particularly in conflict affected areas in the northern part (ACAPS 2017a:7). 6.1 million people in South Sudan are in need of humanitarian assistance (OCHA 2015a:2).

FIGURE 3.1: MAP OF SOUTH SUDAN
(Source: UN 2015)

3.2 Somalia

Somalia is an East-African country of 637,657 square kilometres. The land is principally desert with moderate temperatures in the north and a hot climate in the south. Recurring droughts but flooding in the rainy season are common natural hazards in Somalia. Its population is estimated to be close to 11 million people, but counting is difficult in Somalia because of a high number of nomads, refugee movements and clan conflicts. Internally displaced persons are numbered over a million (CIA 2017).

85% of the population belong to the ethnic group of Somalis. Their language called Somali, is the official language, although Arabic, Italian and English are also being spoken in Somalia (CIA 2017).

Historical background

Somalia had various rulers over the centuries and mainly Islamic dominated (for example: the Omanis and the Ottoman Turks). By the end of the 19th century Somalia was divided into five parts each controlled by a different state

power: Britain, Italy, France, Ethiopia and Kenya (Fitzgerald 2002:21) but at the beginning of the 20th century the northern part of Somalia became an English protectorate and the southern part an Italian one (Shay 2014:2). During World War II, Italy and Britain had military conflicts over Somalia (Fitzgerald 2002:21).

After breaking free from colonialization, the two territories of Somalia became the United Republic of Somalia in 1960. Though united under one government, the North and the South operated as two separate countries (Shay 2014:2) and since then, "Somalia has suffered from political instability and intertribal conflict" (Shay 2014:3).

Political situation

The central authority in Somalia collapsed in 1991, which turned the country into a tumult of war and anarchy. In the same year the northern clans declared independency as Somaliland, although they were not recognised by any government (CIA 2015; Shay 2014:13). The civil war, in addition to a severe drought and the lack of supply of basic products, had a devastating effect on Somalia's residents (Shay 2014:15), and left more than a million refugees and five million Somalians starving within the country (Shay 2014:16).

Although in the year 2004 an interim government (Somali Transitional Federal Government TFG) was formed (Shay 2014:281), the country remained unstable. The militant group al-Shabaab exploited the situation and took control over ungoverned territory as well as important parts of the capital city of Mogadishu and the port of Kismayo (see map below). It is estimated that until October 2012 al-Shabaab's annual collection of custom tolls and taxes in Kismayo added up to 50 million US-Dollars, with which war efforts were funded (Shay 2014:107). Al-Shabaab's aim is to implement the Sharia, the Islamic religious law (Shay 2014:100) and therefore they fight against the Western-backed Somali Government, the African Union Mission in Somalia (AMISOM), the United Nations, and western NGO's (Shay 2014: 98).

After heavy fighting in 2011 for power over the capital city, the militants abandoned most areas of Mogadishu (Shay 2014:135) and in 2012 the whole city

as well as the port of Kismayo were taken back from al-Shabaab (Shay 2014:167). The country's situation remained unstable (CFR 2016) as a result of continued military offensives, violations of human rights (for example: sexual violence against women; forced recruitment of children) and structural challenges (for example: clan structures).

According to Shay (2014:266), the UN-brokered peace process, leading to parliamentary and presidential elections in 2012, was a notable improvement. Despite these promising developments, Somalia remains one of the most dangerous places and its recovery will take many years (Shay 2014:266).

Clan structures

Clans play an important role in the society of Somalia and the consciousness of Somalis. Despite sharing a common language, religion and similar income generating activities, conflicts and rivalries between clans or sub-clans are common (Fitzgerald 2002:21). One quarter of all violent incidents are caused by clan conflicts (ACAPS 2016:33).

Economic situation

Before the Somali state broke down in 1991, crop cultivation and livestock production, forestry and fisheries were the main income sources. The forestry sector as well as the fisheries production remained minor economic activities. Livestock was the predominant agricultural export, whereas crop cultivation (mainly sorghum and corn) in rural areas was for subsistence and internal markets. Sugarcane and bananas were primarily export goods. Drought and the breakdown of the Somali State, followed by the civil war, affected the agricultural production severely (Fitzgerald 2002:17), destroyed the infrastructure and brought other economic activities to a halt (Fitzgerald 2002:27). Today, the agriculture sector is the most important, particularly livestock farming, but Somalia is one of the poorest countries in the world (ACAPS 2017c).

75% of schools were destroyed or closed due to the conflict, and the literacy rate was estimated at 38% in 2001 (newer facts are not available) (ACCAPS

2017c). Until the second half of the 20th century education was provided mostly by Quranic schools.

Humanitarian challenges

A large section of the population is highly vulnerable because of incomplete recovery from the famine in 2011, drought and other natural hazards, but mainly because of ongoing armed conflict and displacement (ECHO 2016:2). Ethiopia hosts currently one of the largest number of Somali refugees, estimated by UNHCR (2017) at 245,000.

An estimated number of 1.1 million people are still displaced internally in Somalia (ACAPS 2016:32), and clashes between al-Shabaab and the military, as well as inter-clan conflicts, continue. The closure of the big refugee camp Dadaab in Kenya brought many Somalis back into their country (ACAPS 2016:31). Their very limited resources leave them vulnerable to exploitation (for example: recruitment for income by al-Shabaab) and their health conditions will further deteriorate due to a lack of health structures, water and sanitation systems (ACAPS 2016:33). Malnutrition and food insecurity is widespread (ACAPS 2017c), but half of the food insecure population cannot be accessed, because al-Shabaab banned WFP in 2010 from the areas under their control (ACAPS 2017c). The total of Somalia's population in need of humanitarian assistance is estimated to be 5 million people (ACAPS 2016:31).

FIGURE 3.2: MAP OF SOMALIA
(Source: UN 2015)

3.3 Medair

Medair is an international humanitarian NGO founded in 1989, based in Switzerland. Medair's mission is to relieve human suffering in some of the world's most remote and devastated places by focusing on health care and nutrition; safe water, sanitation and hygiene; as well as shelter and infrastructure (Medair 2016b:4). The organisation is signatory to the Code of Conduct of the International Committee of the Red Cross (Medair 2016b:38).

Today, Medair has 99 staff members (88 full-time equivalents) working in the headquarters in Switzerland and 1142 field staff, of whom 998 are recruited locally (Medair 2016b:5). The field staff are, at present, divided into teams in Afghanistan, Democratic Republic of Congo, Haiti, Iraq, Jordan, Lebanon, Madagascar, Nepal, Philippines, Sierra Leone, Somalia, South Sudan and

Syria (Medair 2016b:5). More than 1.6 million people were reached with emergency relief and recovery services in 2015 (Medair 2016b:4). Medair's annual budget comes to 64 million Swiss Francs (Medair 2016b:46).

3.3.1 Medair in South Sudan

Medair has worked in South Sudan since 1991 (Medair 2015c). Today, the organisation is involved in programs in Maban, Renk, Malakal, Leer and Bentiu (Medair 2016b:20). The CG model is currently being used at Maban and Renk. In general, unpredictable security conditions are one of the greatest challenges for Medair's work in South Sudan (Medair 2016:21; Medair 2017a:3).

Maban, Upper Nile State

In 2012, tens of thousands of Sudanese refugees fled across the border to Maban County. They overwhelmed the community's capacity to shelter and care for them. Medair sent an emergency health-team to Yusuf Batil camp where it responded to an outbreak of Hepatitis E (Medair 2017b:3). Today, the Yusuf Batil camp has an estimated population of over 40,000 (Medair 2017a:7) and Medair provides long-term emergency response for the refugees and vulnerable host communities (Medair 2013c:2). The overall objective is to reduce morbidity and mortality in the target communities that evolved over time into a multi-sectoral public health programme (Medair 2016c:7).

Medair currently runs a primary health care centre, a nutrition clinic and a 24-hour delivery clinic in Yusuf Batil; and, they also provide water treatment and distribution for the whole camp, as well as training local staff to deliver health and nutrition services (Medair 2017a:7). Besides the above, a CG network has been implemented for teaching households how to improve health, hygiene and nutrition (Medair 2017b:3).

Renk, Upper Nile State

After the independence of South Sudan in 2011, Renk became the main port of entry for the large number of returnees travelling from Sudan to South Sudan. The returnees often stayed for months before they continued their jour-

ney which created challenges in terms of health and WASH services, especially within the returnees' sites (Medair 2014:v). Medair started the provision of health, nutrition and WASH services for the returnees with the overall objective to reduce morbidity and mortality among returnees and the targeted host communities (Medair 2014b:x). Although Renk was attacked several times in 2014 and 2015 (Medair 2015h:1), Medair continued to provide health care and nutrition services, as well as safe drinking water and furthermore opened a 24-hour delivery clinic where women could safely give birth (Medair 2016:21).

In 2017, the global acute malnutrition rates in Renk exceeded the emergency threshold, wherefore Medair provided nutrition and ran a stabilisation centre for severely malnourished children who had medical complications (Medair 2017a:6).

3.3.2 Medair in Somalia

Medair's very first humanitarian intervention in Somalia started in 1992 when responding to the famine (Medair 2014a:11). Medair exited Somalia in 1994 when the projects were completed (Medair 2013a:9). The organisation returned to Somalia in 2008 (Medair 2015c); however, due to the worsening restrictions and the inability to access the area Medair decided to close the South Central Somalia program at the end of 2010 (Medair 2013a:9). Since it opened a base in Burao in the northern part in 2008, Medair has been able to continue responding to the humanitarian needs of host and IDP populations through health, nutrition, WASH and DRR interventions (Medair 2013a:9).

The CG model was initiated in January 2011 as a pilot project at six IDP sites in Burao. The objective of the project was to improve Infant and Young Child Feeding (IYCF) knowledge and practise (Medair 2012:5). The gained experiences with the CGs built the foundation for further usage of the model in other programs (Medair 2012:19).

> A major part of our success in Somalia comes from the strength of our Care Group networks. In 2016, we trained more than 1,000 community health workers and Care Group volunteers to promote good health, hygiene, and nutrition practices in their neighbourhoods, and to encourage people to visit health clinics (Medair 2017a:11).

As the security situation in South Central Somalia improved, Medair re-established a presence in South Central Somalia in the City of Mogadishu in 2013, focusing on providing health and nutrition services to vulnerable host and IDP populations (Medair 2013:9). In 2015, Medair's operations in South Central Somalia extended to Kismayo. Primary health care activities are being supported in partnership with three local NGOs (Somali Aid, DAWA, Zamzam) (Medair 2015f:2).

> In 2016 […] insecurity continued to be an obstacle to our work, restricting our staff movements, but we successfully partnered with three trusted local agencies to carry out our mission (Medair 2017a:10).

Working with local communities in urban areas and displacement camps and selected health volunteers that facilitate community level dialogue established a strong linkage between communities and health facilities (Medair 2016:24). This proved a key strength in Medair's programming in Somalia (Medair 2015f:10).

3.4 Conclusion

This chapter provides basic background information to the case study. The two focal countries South Sudan and Somalia, including their history, the economic situation and the need for humanitarian assistance were briefly described. Both countries face protracted crises that concomitantly challenge NGO work. Medair, one of these humanitarian NGOs and the implementing organisation of CGs in the case study has been introduced, followed by an overview of its programs in the two countries.

The next chapter provides the research methodology and describes the data collection as well as the analysis of the gathered data.

CHAPTER FOUR: METHODOLOGY AND RESEARCH DESIGN

This chapter describes the path towards the data collection, the data collection itself, and the analysis of the information gathered. The research design served as a framework for all intended steps of this study for gathering, analysing, and triangulating the necessary data (De Munck 2009:11) and finally reaching the research objective: *Analysis of the application of the Care Group Model in a relief context in light of its original design and methodology for a development setting.*

The findings of this research are described and discussed in the following chapters.

4.1 Research approach

This study follows a qualitative research approach for investigating the application of a development model in a relief context in practice and for putting the findings back into practice. Organisational functioning and cultural phenomena as well as context related decisions/obstacles can best be explored through qualitative research (Strauss & Corbin 1998:11) because the nature of a qualitative research is descriptive and explorative. It is a process of developing a theory in which the researcher is a part of the research (Flick 2006:19). The resulting missing objectivity of the researcher is, according to Helfferich (2009:157), not seen as a deficit if acknowledged and constantly reflected on (Helfferich 2009:155).

The process of qualitative research is time-consuming (interviewing, transcribing and analysing the statements are not quickly completed) which can be a downside (Flick 2006:21) that should be taken into account when designing the research.

This study concentrates on the case of Medair using CGs in South Sudan and Somalia and contrasting the experiences in these two countries. Case studies in general aim to gain insights into an individual organisation or situation and to constitute, *inter alia*, a representative example (Newby 2010:253). According to Stephens, the case study

> […] offers us an opportunity to maximise the cultural and contextual realities 'embedded' in the international setting of the research and to produce analyses of depth and complexity (Stephens 2009:47).

Flick (2006:14) uses the term "formative evaluation" for the process of examining the application of an intervention and Patton (2015:13) uses the expression of "qualitative inquiry". The contribution of the qualitative inquiry is, for example: understanding a context and how and why it matters; studying how things work; and identifying unanticipated consequences (Patton 2015:13). It aims not only to assess an organisation's intervention but it captures the different subjective grading of all participants (Flick 2006:19).

4.2 Research design

The research design is the framework used to carry out the aim of the research project. It binds together the theoretical framework, the research objective, the methods, and the available resources (Flick 2003:264). Beside the objectives, methods and tools, the time and financial resources had to be taken into consideration when defining the research design (Flick 2003:264). The research design served as a framework for all intended steps of this study, for gathering and later analysing the necessary data, a blueprint that the researcher tried to follow (De Munck 2009:11). An overview of the executed steps follows:

FIGURE 4.1: RESEARCH DESIGN

4.3 Research methods

Case studies use a variety of sources (for example: documentary sources, external reports, evaluations, data collected from interviews and observations, etc.) and therefore the findings can be triangulated (Newby, 2010:52). This master's dissertation used both primary and secondary data sources.

Literature review

Literature about for example: LRRD, asset-based community development, the history and context of Somalia and South Sudan formed the theoretical basis of the case study. Access was ensured *inter alia* through the student's membership of the central library in Zurich and the internet. The Care Group Network was one of the main sources for documents describing the concept of the Care Group Model, as well as project documents of other NGOs using CGs in relief settings.

Document analysis

Medair's own evaluations were a fundamental source for outlining the case study and reconstructing the project status of the work of Medair in Somalia and South Sudan. Medair documents were used for triangulating the interview data. The organisation has given access to project documents, evaluations, surveys, newsletters, and reports.

Expert interviews

Local and international staff of Medair were the source for the primary data, gained through expert interviews. The interviews were not about the personal lives of the interviewees, but about their experiences with and knowledge of the Care Group Model. The participants are therefore experts, and the interview guide was more structured than for a narrative interview (Helfferich 2009:164).

4.4 Sampling

According to Flick (2003:262), the so called "theoretical sampling" is considered the ideal solution for qualitative research; however, this is not the case if the aim is for example: to evaluate organisational practice. It was decided

therefore to use the “selective sampling technique” for selecting the interviewees that determines the number of samples and their relevant characteristics before starting the field research (Kelle & Kluge 2010:50; Saldaña 2011:33). When working with the selective sampling technique the data is analysed after conducting and transcribing all interviews (Kelle & Kluge 2010:50).

The question of “How many participants are enough?” is dependent on many factors according to Saldaña (2011:34). He does not recommend a certain number of interviews; instead he asks whether there is a big enough body of data (Saldaña 2011:34). In the available case study, the number of participants and the selection criteria were dependent on Medair’s staff situation in Somalia and South Sudan.

In South Sudan there are three Medair staff, and in Somalia there are also three Medair staff, involved in the work with CGs. A former Medair staff member who had worked in Somalia and in South Sudan as well as a Medair staff member who used to work in South Sudan complemented the samples and therefore a sample size of eight interviewees was defined. After conducting the expert interviews, the researcher decided to submit an additional request to the Senior Health and Nutrition Advisor for an interview. The need for more in-depth background information of Medair using CGs was felt. Eventually, the researcher had nine recorded and transcribed interviews available.

TABLE 4.1: CHARACTERISTICS OF INTERVIEWEES

Name	Country	Project	Position	Current or former staff	Nationality	Gender	Age
Len	South Sudan	Maban & Renk	Program Funding Manager	Current	USA	M	30-35
Jacob	South Sudan	Maban	Senior BCC Officer	Current	South Sudan	M	31
Daniel	South Sudan	Renk	Senior BCC Officer	Current	South Sudan	M	30-35
Laura	South Sudan	Maban & Renk	WASH Advisor	Former	USA	F	35-40
Evan	Somalia	Mogadishu	Deputy Country Director	Current	Kenya	M	36

Name	Country	Project	Position	Current or former staff	Nationality	Gender	Age
Ajib	Somalia	Mogadishu	CG Officer	Current	Somalia	M	34
Fatima	Somalia	Mogadishu	Community Health Manager	Current	Somalia	F	28
Susan	Somalia & South Sudan		Health & Nutrition Advisor	Former	France	F	35-40
Emma	Somalia & South Sudan		Senior Health & Nutrition Advisor	Current	USA	F	54

The interview partners mentioned in table 4.3 are experienced in working with the Care Group Model within the context of either South Sudan or Somalia. Minimising the distinctions of the samples increased the probability to find similar data and to confirm their relevance (Kelle & Kluge 2010:47;48), although they occupy different roles and have various cultural backgrounds. The balance between international and national staff had to be maintained as much as possible. Cultural insights from national staff were particularly valuable, and their experiences and knowledge was sought in the interviews. The participants' age, gender, religion etc. was not decisive for defining the samples in this research.

4.5 Data collection

One source of primary data for this study was documents provided by Medair. The organisation made available 27 documents concerning the CGs in South Sudan and 12 documents about the work with CGs in Somalia. The contents of the documents were surveys, evaluations, donor proposals and project reports. Additionally, the researcher had access to annual reports and newsletters of Medair.

The main source of empirical data was Medair staff who were interviewed by the researcher. The questions for the expert interviews had crystallised after the literature review and after the theory of the CG model had been studied and brought together with the analysis of the context of South Sudan and Somalia. All interviews were conducted via Skype, recorded, and transcribed. The participants were experienced in using the CG model in their working context and were, therefore, considered 'experts' (Helfferich 2009:166). The

interview guide was more structured than in a narrative interview (Helfferich 2009:164), although a certain flexibility and space for additional remarks were still possible (Helfferich 2009:36).

4.5.1 Interview guide and pre-interview questionnaire

For a better overview, the questions were divided into different sections, for example: context where CG are being used, CG criteria, and LRRD, etc. In every section, two to three key questions were formulated and supported by more detailed questions. The latter were used in case the interviewee did not understand the key question properly or if the key question was not answered fully.

After compiling the interview guide, the interviewer realised that there were too many questions for appropriate interview duration. It was therefore decided to create a pre-interview questionnaire (see Annexure A). The questionnaire's aim was to get the facts and figures about the CGs and the respective project status, whereas the interviews focused on the experiences of the interviewees with using the CGs in a relief setting.

The pre-questionnaire was sent only to the Deputy Country Director in Somalia and to the Program Funding Manager in South Sudan. The pre-questionnaire was not sent to all interviewees because it was meant to collect facts and figures and therefore one knowledgeable Medair staff member was enough to collect all the data required. It was also necessary to consider that Medair staff are already stretched in terms of workload and participation in this research was a large commitment for each interviewee.

4.5.2 Pilot interview

Through the "Care Group Forward Interest Group" the researcher got in contact with the Senior International Nutrition Technical Advisor of Samaritan's Purse: an American NGO. She was willing to take part in the pilot interview of this study. Due to a limited number of Medair staff who could be interviewed, the decision was made to conduct the pilot interview with a non-Medair staff member. She was asked because of her experience in overseeing projects that use CGs in South Sudan.

The interviewee answered the question in a focused manner and did not need to ask clarifying questions, which indicated that the questions were understood properly and needed only minor adjustments. The interview duration was around 35 minutes that was considered an appropriate length.

Since a major portion of the data for this qualitative research was collected through communication, the researcher/interviewer had to reflect on her role as well as that of the interview itself. Helfferich (2009:24) defines basic principles of qualitative interviews, such as the principle of communication, the principle of openness and the principle of reflexivity. The pilot interview was conducted by audio via Skype only and so the interview partners could not see each other. Signs of misunderstanding, signs of hesitation, signs of unwillingness to answer a question, and other issues had to be heard and could not be proved by the interviewer through, for example, the body language of the interviewee. It was a good preparation for the following interviews that were also conducted via Skype. Another challenge that had to be considered in the process of post-interview reflection was that firstly, the researcher/interviewer was not interviewing in her native language and secondly, the interviewee was speaking her mother tongue. These factors hindered the interviewer in a few incidents to make more detailed enquiries in good time.

The principle of openness (Helfferich 2009:114f) was not in danger since the questions were pertinent and did not involve subjective observations. It was not difficult for the interviewer to accept the answers without commenting or assessing them.

After conducting, utilizing, and reflecting on the pilot interview, the researcher made minor adjustments in the formulation of the questions that resulted in the interview Guide for Expert Interviews (see Annexure B). After finalizing the interview guide, the interviews with the selected Medair staff were scheduled and the pre-interview questionnaire was sent to the Deputy Country Director in Somalia and the Project Funding Manager in South Sudan.

4.5.3 Expert interviews

All the interviews took place within two months and the duration was between 30 and 50 minutes each. They were carried out via Skype and not *in situ*. Reasons for this relate to security issues in Somalia and South Sudan, limited financial resources, and the family situation of the researcher. This could be considered as a limitation of this study.

Depending on the country of current stay of the interviewee, the stability of the internet connection was a challenge. In some cases, the line was interrupted several times during the interview. Since all the experts and the researcher are used to such, the interruptions did not lead to a loss of quality of answers and the persons involved remained concentrated. One interview could not be conducted via Skype due to technical challenges and it was made available in written form.

The researcher and some of the interviewed experts are not native English speakers and therefore a language barrier occasionally presented. The consequence was that some questions were only partly understood or answered.

All interviewees signed the Consent Form for Interview (see figure 4.1).

After transcribing the interviews, one interviewee asked to read the transcription, but did not change or comment anything, except for emphasising that she would be willing to assist should further questions occur. Another interviewee sent a short e-mail message right after finishing the interview. It was important to her to specify her answer to one of the questions. This statement was considered during the data analysis.

4.6 Data analysis

The data gained by interviewing Medair staff had to be handled and analysed carefully. The qualitative research approach “Grounded Theory (GT)”, developed by Strauss and Corbin, constitutes the analysing method of the available transcribed expert interviews. It is a method of discovery (Saldaña 2011:95) and allowed the researcher to work with the data in detail and gain solid

knowledge. The software MAXQDA12 was used for the process of analyses which corresponds with the GT.

Key process in the GT is the analysis of the data called “coding”. The findings gained during the coding cycle allow the researcher to build new theories (Strauss & Corbin 1996:39).

> These codes function as a way of patterning, classifying, and later reorganising each datum into emergent categories for further analysis (Saldaña 2011:95).

As mentioned above, the researcher is part of the research when using a qualitative approach thereby meaning that different researchers analysing the same data “may develop different codes, depending on their lenses and filters” (Saldaña 2011:97). There is no one right procedure of coding and a researcher’s individual style of handling the data is part of empirical studies (Breuer 2009:79).

The first part of the GT coding cycle is called “open coding”, followed by “axial coding” and “selective coding”. These steps of analysing the available data shall be described in the next sections. In doing so, one has to bear in mind that the structure and succession is not straight, but rather characterized by repetition, surprises or detours (Breuer 2009:78).

4.6.1 Open Coding

Open coding matches text passages with codes which are divided into subcodes that are bundled into categories (Breuer 2009:71). For this purpose, the transcribed interviews were opened with the software MAXQDA12, and particular words, a part of a sentence, whole sentences or a segment comprising several sentences were matched with previously defined codes. The basis for defining the codes before the open coding is a deductive way to approach the data. According to Saldaña (2011:93), deduction is the analytic strategy to explore from the general to the particular, whereas induction transfers a theory from the particular to the general. Abductive reasoning hypothesizes a theory based on the gained evidence (Saldaña 2011:93).

The researcher decided for a second open coding and divided existing codes into sub-codes: for example: the code “Context” contained in total 15 codes for Somalia after the first coding cycle. The researcher then sorted the differ-

ent contexts into three sub-codes “Political context (4)”, “Cultural context (17)” and “Project context (11)” and then worked through the interviews again, leading to a total of 32 codes about the context of and in Somalia.

During the second open coding, deduction and induction were exchanged and new codes emerged from the data, for example: the interviews were deductively searched after text segments about volunteering that matched with the code “CG Criteria”. In that process, the inductive insight (emerging from the data) was gained that *the concept of volunteering for the community was not a value anchored in the Somali culture*.

In conducting this first step of the coding cycle, the researcher also defined so called in-vivo codes. These codes are not created by the researcher, but emerge from the interview as a remarkable statement of the interviewee. The phrasing has to be adopted (Breuer 2009:78); for example: “How are we creating those safe and reliable spaces for learning from each other?” was considered to be alone-standing and a noteworthy part of a sentence and was thus defined as an in-vivo code.

Further to this, the researcher took notes as soon as the data revealed an interesting aspect, a new insight, a consequence or other coherences. These notes are called Memo. According to Breuer (2009:103), the three main categories of memos are: code memos, theoretical memos and planning memos. They will lead the researcher through interpretation of the findings (Saldaña 2011:98; Breuer 2009:103).

For example, “Contextualization – mentioned in Evan's interview as well” or a memo about the intention of comparing statements in a later stage of coding:

> Compare with Susan's and Evan's statement about the importance of having someone who passionately pursues the implementation of the CG model.

4.6.2 Axial Coding

Axial coding is the process of firstly grouping of codes and categories (Breuer 2009:77), and then discovering connections between the codes and categories, similarities, cohesions or contrasts (Strauss & Corbin 1996:75). The so called “paradigm model” is a technique to achieve the recomposing of the da-

ta (Strauss & Corbin 1996:75; Breuer 2009:77) by focusing on causal conditions of a category, its context, intervening conditions, its action and interactional strategies, consequences (Breuer 2009:84). The meaning of these aspects shall be explained according to Breuer (2009:86):

- Causal conditions: what led to the situation?
- Context: attributes of the situation (for example: place, duration, cultural environment, individual biography)
- Intervening conditions: what caused a reaction or hindered a reaction (for example: time, culture, economic situation)?
- Action and interactional strategies: goal-oriented processes of action
- Consequences: intended and unintentional consequences of action and interaction

Following the paradigm model challenges the researcher to think in terms of correlations and conditions (Breuer 2009:87).

The researcher decided to look at the interviews of the two countries in the case studies separately for the axial coding, contrary to the open coding. The reasoning behind this can be found in secondary research objectives (3).

4.6.3 Selective Coding

Selective coding is the continuation of the axial coding: aiming to find the core category and finally developing a theory. The above described paradigm model serves as a tool not only in the process of axial coding, but also for the selective coding (Breuer 2009:92). The categories developed during the axial coding were then analysed on a more abstract level and in relation to the research objective, as well as newly combined or complemented by the codes defined through the open coding process (Strauss & Corbin 1996:109). The researcher was challenged to decide which codes are most important and contribute best to reach the research objective. According to Breuer (2009:92), the selective coding process is based on the efforts and the work of coding previously conducted coding cycles.

The essence of each paradigm, based on the axial coding process, was then put in relationship with other categories and refined, which ensured the valida-

tion of relations of the data (Strauss & Corbin 1996:109). The feature “Code-Matrix-Browser” of MAXQDA12 was especially useful in this phase of coding.

4.6.4 Document analysis

During the previously described coding cycles, the researcher made use of the pre-interview questionnaire, which provided additional information about the work settings of Medair in Somalia and South Sudan. That part of the data collection was integrated and analysed parallel to the interviews and the gained knowledge was captured as new memos.

For the purpose of triangulation, the available project documents from Medair were consulted. They were analysed country by country and with the same code system as the interviews during the open coding; however, the researcher already had the clusters of the codes as developed during the axial coding process in mind as well as the relation with the research objective. Using an identical code system made an immediate comparison of data possible.

The process of triangulation seeks the validation of, for example: an outcome through two different sources (Newby 2010:122), and the complementation of perspectives (Kelle & Erzberger 2003:304; Flick 2006:16). Triangulating the findings allows one to integrate several methods and to combine different sources of data (Flick 2009:445). In this study, not only the variety of documents contributed to the triangulation, but also the different roles, tasks and cultural backgrounds of the interviewees as well as their individual experience of the very same process.

In a modest way, relating and mutually validating the outcomes with qualitative as well as quantitative data (Flick 2006:16) was also made possible through qualitative surveys and their results received from Medair (for example: KAP survey).

4.7 Ethical considerations

The study did not present any risks to participants. To prevent unforeseen harm, every interviewee received the “Consent Form for Interviews” (see Annexure C) before the data collection was conducted. Participants were formerly advised to ask for clarification when desired after careful reading of the document. After the participants formally agreed to the terms, the researcher got back the duly signed Consent Form for Interviews. All participants signed the consent form for the interviews. This kind of contract served a dual purpose. Firstly, the signed contract served as a tool for providing the contact details of the researcher to the participants, and secondly, to protect the rights, dignity and safety of the interviewees, which are main issues when conducting qualitative research (King & Horrocks 2010:105). Therefore, pseudonyms were used in this master’s dissertation instead of the participant’s real names.

4.8 Conclusion

This chapter outlined the approach and the design of this study as the foundation of the then following data collection. Data sources as well as the data collection were described, which are mainly the expert interviews with current or former Medair staff. Before interviewing the participants, the interview guide was tested in a pilot-interview. The theoretical basis of the data analysis, the coding cycle according to the grounded theory, was elaborated on before closing the chapter with the ethical consideration contained in this research.

The next chapter outlines the process of data analysis as well as the findings.

CHAPTER FIVE: PROCESS AND RESULTS OF DATA ANALYSIS

This Chapter contains the description and the results of the data analysis. Firstly, the data gained through the expert interviews will be presented. According to the Grounded Theory, the findings of the Open Coding are presented first, followed by the Axial Coding and the Selective Coding. Finally, the findings of the document analysis and the triangulation of the data is added and brought into relation with the research objectives.

5.1 Results of the coding process

5.1.1 Process and results of Open Coding

After importing seven out of the nine transcribed interviews into the software MAXQDA12, the researcher defined the main categories on the basis of the interview guide. Each category was divided into the two countries of the case study, Somalia (SOM) and South Sudan (SDS), for comparing the codes in accordance with the research objectives (3). After deductively working through all the interviews, 487 codes (shown in figure 5.1.1), 13 in-vivo codes and 7 memos were defined.

	Category	Code	No of Codings
●	Topics covered in CG	SDS	21
●	Topics covered in CG	SOM	19
●	Operation of CG	SOM	49
●	Operation of CG	SDS	58
●	Target group/Volunteers	SOM	25
●	Target group/Volunteers	SDS	28
●	Reason for working with CG	SOM	9
●	Reason for working with CG	SDS	6
●	Impact of CG	SDS	11
●	Impact of CG	SOM	11
●	Sustainability of CG	SOM	12
●	Sustainability of CG	SDS	12
●	Partners	SOM	9
●	Partners	SDS	8
●	Program activities beside CG	SOM	2
●	Program activities beside CG	SDS	3
●	Involvement of the community at the beginning	SOM	17
●	Involvement of the community at the beginning	SDS	6
●	Context	SOM	15
●	Context	SDS	23
●	Output of CG	SOM	22
●	Output of CG	SDS	27
●	Challenges of using CG	SOM	18
●	Challenges of using CG	SDS	36
●	Recommendations		31

FIGURE 5.1: RESULTS AFTER THE FIRST OPEN CODING

Due to technical challenges, one of the expert interviews was not conducted via Skype. Several trials did not work out and consequently it was decided to accept the interview in writing. The transcribed interview with the Senior Health and Nutrition Advisor and the written interview were imported into the software MAXQDA12 after the first open coding.

In a second open coding, additional categories were inductively developed and corresponding interview passages were coded. Furthermore, existing categories were divided in sub-categories, for example: the category “Context” was divided into the sub-categories “Political Context”, “Project Context”, and “Cultural Context” through which the focus of separation of the two countries continued. Some sentences or passages were dragged into two different categories or sub-categories, as the following example shows.

> […] that's why we give the communities the right to select their own person. The fifteen households, they decide whom to select. Because they are the ones– that person will be able to visit the households, talk with them about their beliefs, especially health and nutrition related. So, we want them to be able to be the ones who select, because if we select we might select somebody who is from a different clan; we might select somebody who they don't like, and then they may refuse that person to visit them and to give health messages (Interview Evan).

This passage was assigned to three (sub-) categories: "Context/Cultural context", "Target Group/Volunteer/Culture" and "Challenges of using CG/Culture", all belonging to Somalia.

The alternately deductive and inductive work during the second open coding resulted in a total of 762 codes, shown in figure 5.2., 18 in-vivo codes and 35 memos.

	Category	Code	No of Codings
●	Reason for working with CG	SDS	8
●	Reason for working with CG	SOM	9
●	Target group/Volunteers	SDS	
	SDS	culture	8
	SDS	religious & educational background	10
	SDS	section of population	13
●	Target group/Volunteers	SOM	
	SOM	section of population	11
	SOM	culture	12
	SOM	religious & educational background	9
●	Operation of CG	SDS	
	SDS	Participation (Start)	0
	SDS	Formal & informal analysis	5
	SDS	Meetings	6
	SDS	Coverage & information flow	14
	SDS	Data collection	3
	SDS	Teaching	13
	SDS	Volunteers and their tasks	7
	SDS	Promoters and their tasks	4
	SDS	Training	1
	SDS	Organisation of CG & Numbers	16
●	Operation of CG	SOM	
	SOM	Data collection	5
	SOM	Teaching	9
	SOM	Organisation of CG & Numbers	9
	SOM	Volunteers and their tasks	18
	SOM	Promoters and their tasks	13
	SOM	Coverage & information flow	7
	SOM	Meetings	3
	SOM	Formal & informal analysis	3
	SOM	Participation (Start)	5

FIGURE 5.2: RESULTS AFTER THE SECOND OPEN CODING

Category	Code	No of Codings
Topics covered in CG	SDS	21
Topics covered in CG	SOM	22
Program activities beside CG	SDS	4
Program activities beside CG	SOM	2
Partners	SDS	8
Partners	SOM	12
Sustainability of CG	SDS	16
Sustainability of CG	SOM	12
Impact of CG	SDS	16
Impact of CG	SOM	11
Output of CG	SDS	29
Output of CG	SOM	24
Challenges of using CG	SDS	
SDS	Workload, responsibilities	6
SDS	Culture	3
SDS	no payment (volunteering)	4
SDS	Consequences of relief setting	17
SDS	CG Criteria	5
Challenges of using CG	SOM	
SOM	no payment (volunteering)	8
SOM	Workload, responsibilities	3
SOM	Culture	6
SOM	Consequences of relief setting	3
Context	SOM	0
SOM	Political context	4
SOM	Cultural context	16
SOM	Project context	11
Context	SDS	0
SDS	Project context	27
SDS	Cultural context	10
SDS	Political context	6
Involvement of the community at the beginning	SOM	19
Involvement of the community at the beginning	SDS	6
Recommendations	concerning volunteers & staff	14
Recommendations	concerning CG criteria	7
Recommendations	concerning the context	13
Recommendations	concerning NGO's attitude	12
	Backing through staff	12

(CONTINUATION) FIGURE 5.2: RESULTS AFTER THE SECOND OPEN CODING

Lexical analysis

Lexical analysis was conducted as a part of the second open coding: the documents were searched for key words. Since no wording appeared as exceptional or very different when interviewing the participants, the researcher decided to search the documents for key words related to the research objectives that had not yet formed a category. “Success” was one of the words of the lexical analysis that led to a new category with 17 codes; the word “key”

built the new category “key aspects”, containing 15 codes. These two new categories did not reveal significant findings immediately but became crucial in the axial coding process (see 5.1.2).

In-Vivo Codes

In-vivo codes were defined during both open coding rounds. Significant statements or passages that stood alone, when compared with the other interviews, formed an in-vivo code:

> […] but actually, something a little bit more linked to their dignity and psychological wellbeing (Interview Laura).

This statement was strongly linked with the context of Medair’s work in South Sudan where many women live a burdensome life (compare with the statement: “[…] especially with rape, because that’s a big part of what’s happening in South Sudan.” Interview Laura). The interviewee emphasised the opportunity to support people (mainly women) through CGs in this relief context in a more holistic way without devaluing the provision of, for example, safe drinking water or health services.

Most of the in-vivo codes led to a memo as shown in the following examples:

> […] volunteering to the community freely is something very new (Interview Ajib).

This in-vivo code marks a statement made after reflecting the difficulties Medair staff sometimes face when being asked by the volunteers for money or other incentives. It led to the memo below:

> Volunteering is on one hand not known in many cultures (see Interview Ajib). AND: In a refugee camp or in an IDP settlement, people have lost everything and are struggling with their daily life (see Interview Laura) -> other priorities as volunteering. Important to remember when applying the CGs in a relief setting.

A further sentence was in-vivo coded because it mentioned a possible peace building aspect of the CGs. This is a relevant factor when using the model in a relief setting such as in a chronic conflict situation.

> When built the CG, it been started social interaction, which support– which support in the peace. And also, social trust, because in the last 20 years it's a lot– social trust in the community has been lost (Interview Ajib).

The memo below was linked with the above mentioned in-vivo code:

> See also pilot interview with Julie -> tool for peace building

Code-Matrix Browser

The software MAXQDA12 provides the so-called Code-Matrix Browser as one of the supportive features. This matrix shows the correlation between the interviews and the frequency of codes appearing per interview. For example, 12 passages in Len's interview were coded with "Success", as shown in table 5.1. He emphasised the "Success" of the CG model, whereas Laura explained more about the project context, resulting in a total of 16 codes "Project context".

TABLE 5.1: EXAMPLES OF RESULTS OF THE CODE-MATRIX BROWSER

Interview	Code name	No. of codes	Example
Len	"Success"	12	"But, we think we had a lot of success rolling out the model. I think one reason for that is the kind of a controlled camp setting. We're able to more easily target the beneficiaries and it is just easier– like people are much closer together."
Ajib	"Cultural Context"	8	"They only want, she stays at home."
Laura	"Project Context"	16	"And so, we were working a lot with populations that are moving around. And maybe we had them for a few years, so they will likely go back home or move to another place."
Fatima	"Involvement of the community at the beginning"	7	"The first phase is community mobilisation and awareness where at the villages elders and the communities are informed on the project."
Evan	"Recommendations concerning NGO's attitude"	7	"[…] it is always good to contextualise the situation and try to adapt as much as possible, but also trying to maintain the basics of CG. For example, it is always important to make sure that the project belongs to the community. It is not an organisation project."
Jacob	"Sustainability of CG"	8	"Is all about empowering the community, so whether we are there or we are not they know how to help themselves."

Interview	Code name	No. of codes	Example
Susan	“Recommendations concerning the context”	7	“So, if it’s not set up before people start to move, it’s impossible.”
Daniel	“Consequences of relief setting”	5	“[…] but with deteriorating security situations, demand for food has become great and insufficient as well a health services. There is great dependability on NGOs for these services.”
Emma	“Program activities beside CGs”	9	“So, most of the programming where we are doing CGs is health and nutrition and water and sanitation. So, we're doing those three streams of programming. So, if we talk about South Sudan, they would have those sectors. If we talk about Somalia would definitely be health and nutrition and maybe a touch of WASH– you know, depending on the area.”

Using the Code-Matrix Browser gave an overview about some of the main emphasises of each interviewee. This helped in a later step of the data analysis when one of the aspects became more important. It also helped to identify statements requiring scrutiny.

5.1.2 Process and results of axial coding

The process of axial coding aimed to achieve the recomposing of the data (Strauss & Corbin 1996:75; Breuer 2009:77). Based on the research objectives, and where useful, the researcher separated the CGs in Somalia and the CGs in South Sudan for the process of axial coding. This supported a direct comparison of the two countries of operation.

Code-Relations-Browser

As a first step, the “Code-Relations-Browser”, another tool provided by the software MAXQDA12, was used to get a picture of clustered overlapping of categories. As illustrated in figure 5.3, the marks differ in their size and colour, according to the numbers of overlapping of categories and codes.

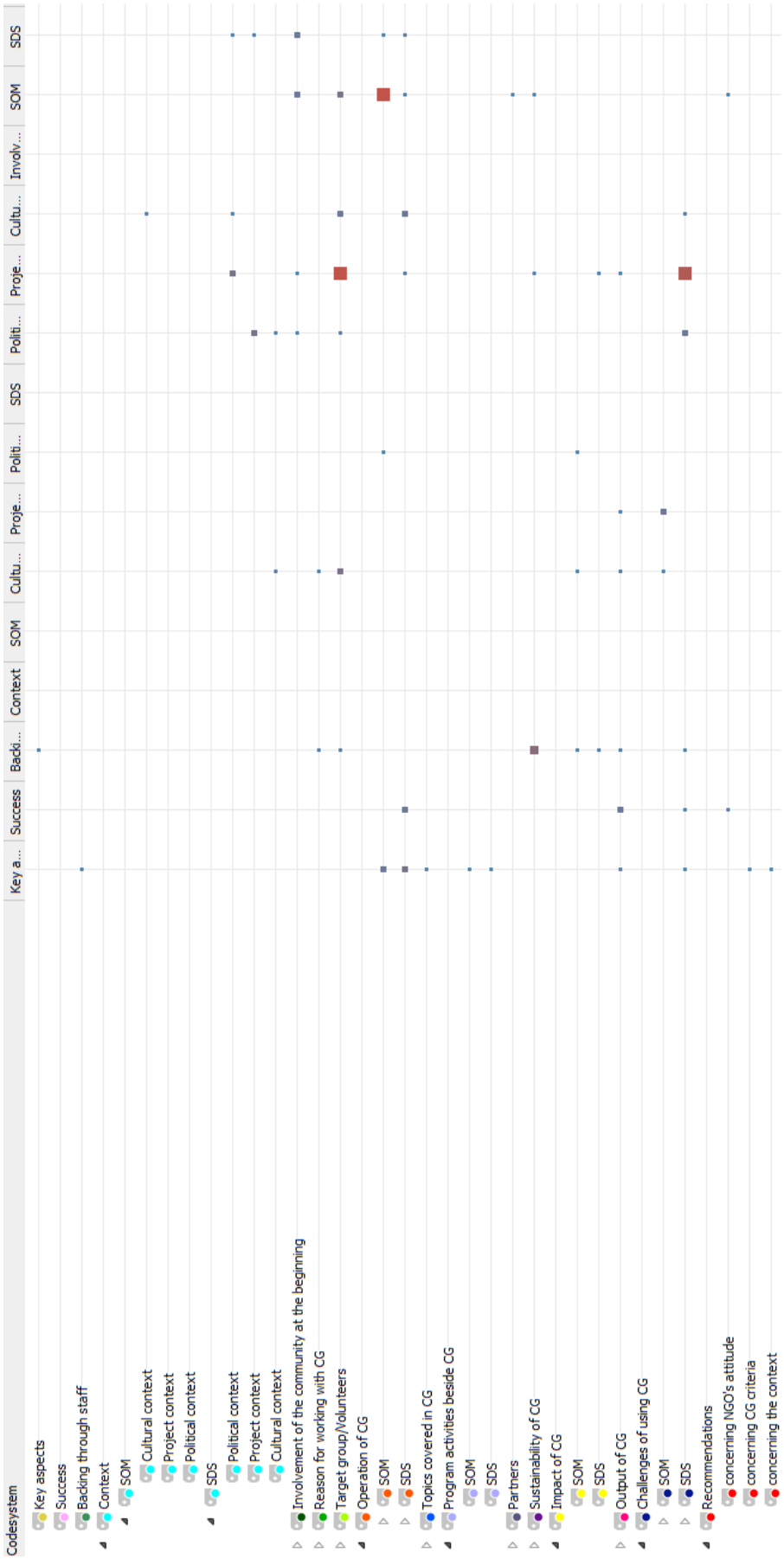

FIGURE 5.3: CODE-RELATIONS-BROWSER

For example, the category “Output of CG/SOM” had seven overlapping with “Topics covered in CG/SOM”, accentuating that the teaching of a certain topic shall lead to an output:

> Same thing with hand washing practices, we've seen it go from 27 to 74%, diarrhoea prevalence we've seen it go from over 50% to like 17% (Interview Len).

Figure 5.4 illustrates code relations by the example of the category “Sustainability SDS”. Its association with the different codes are shown in the box on the right.

The researcher realized that the topic of sustainability, including the idea of long-term impact, was very present when it came to CGs (→ code: “Backing through staff”). She discerned the variety of preconditions (→ code: “Operation of CG/SDS/Teaching”) for sustainability of the CG model and its correlation with the context (→ code: “Challenges of using CG/SDS/Consequences of relief setting”) as the selected following interview passages underline:

“Backing through staff”

> So– ja, I would definitely say it’s a good– it’s an excellent model to also– for the society to survive and get over the tragedy they are in (Interview Susan).

“Operation of CG/SDS/Teaching”

> So, in that way we were able to link across the sectors well, so when we would see (.) more people with increased diarrheal incidents then they could tell the WASH team: “Hey, you know, in this region, in this CG they're having a much bigger problem. Can you go and check their water resource?” And we could link in like that (Interview Laura).

“Challenges of using CG/SDS/Consequences of relief setting”

> Our major hope is that the model will remain since it’s voluntary. However, the problem of poverty and economic situation may hinder it (Interview Daniel).

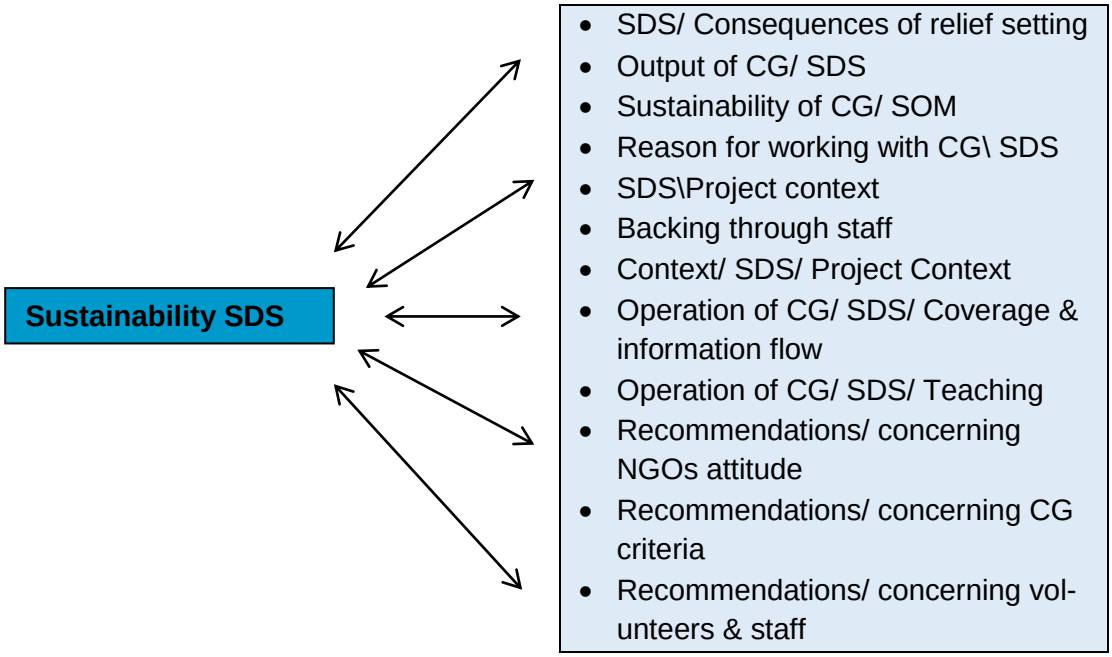

FIGURE 5.4: EXAMPLE OF THE CODE-RELATIONS-BROWSER

Further findings out of the Code-Relations-Browser that served, among others, as a road map for the axial coding are:

- "Recommendation/ concerning the context" can be found in ten different categories or sub-categories; the context where CGs are being implemented seems to play a major role.
- "Success" and "Output of CG" are linked, as well as "Output of CG" and "Topics covered"; the topics that are being talked about in the CGs lead to an output (changed behaviour), which is considered as a success.
- "Operation of CG/ Coverage & information flow" is related to "Challenges of using CG/ Consequences of relief setting"; the latter is a determining factor of the coverage which is going to be achieved (for example: a moving population hinders a broad coverage).
- "Operation of CG/ Coverage & information flow" is a determining factor of "Output of CG", but coverage is at the same time an output of CGs. These two categories are therefore closely linked.
- "Output of CG" and "Sustainability of CG" are related in a sense that changed behaviour is an achievement that sustains in the lives of the participants.

Results of Axial Coding

During the process of axial coding, the researcher followed the paradigm model; thus, focusing on causal conditions of the phenomenon, its context, intervening conditions, the action and interactional strategies and their consequences (Breuer 2009:84). The categories were set in relation which were validated again and compared through the open codes within the corresponding category. Table 5.2 illustrates how the researcher related the aspects of the paradigm model with categories and how the interview statements validated this relation.

TABLE 5.2: EXAMPLE FOR INTERRELATED CATEGORIES

Aspect of Paradigm Model	**Category**	**Illustrating code(s)**
Causal Condition	Involvement of the community at the beginning	"So, the refugee camp they have quite a strong local governance structure with Sheiks and the community leaders and so we really– first is focus group discussions and that with the MEN to *[not understandable]* what the topic was going to be around family planning and what some of the challenges are." (Interview Laura)
→ Causal conditions lead to the phenomenon **"Application of the CG model in a relief setting"**		
Context	Project Context	"They came from Sudan […]. But now according to our settings here, our community is static." (Interview Jacob)
Intervening condition	Challenges of using CG/ SDS/ Culture	"In our context in South Sudan a big challenge was *[not understandable]* making sure that the content is representative for the target group. So specifically thinking of ethnic and tribal identities, so are the pictures appropriate. If they look like the other tribe, we already had problems. We even just– we regularly had to make sure that each message was civic to that area, people really quickly rejected anything." (Interview Laura)
→ Intervening conditions are the underlying factors for the strategy		

Strategy	Operation of CG/ SDS/ Teaching	"[…] whereas in Maban– ja, it was more important to make sure that the messages, activities, of the meetings, that everything was very customised to– to the people *[not understandable]* because it's unique in the country." (Interview Laura)
	Recommendations/ concerning volunteers & staff	"[…] sometimes language can be a barrier so it is good to have promoters from the same community." (Interview Daniel)
→ Strategy and action lead to consequences		
Consequences	Output of CG/ SDS	"[…] the volunteers are now being like examples who in the community exclusive breastfeed their children, now also their neighbours are copying from them. But now, what has– what we also realised; there is a very great reduction in terms of morbidity and mortality just within the camp." (Interview Jacob)

Further significant findings of the axial coding process are presented in the following paragraph. Where useful in regard to the research objective (3), the two countries of the case study, South Sudan and Somalia, were looked at separately.

1. Phenomenon

Through the lexical analysis, "Success" was defined as a new category. Additional to the aspects and relations revealed through the Code-Relations-Browser, the research objectives were considered.

The application of the CG model in a relief context is being analysed in this study, indicating that the model was implemented according to the CG criteria. Although forming a category, the word "success" or "successful" became unnecessary because the NGO using CGs would not be allowed to call the model CG if it did not follow the criteria. An application of the CG model already implies "success" in terms of putting the CG criteria into practice.

> But we can't call it CG, because it doesn't– it misses a few of the criteria (Interview Laura).

This led to "Application of the CG model in a relief setting" as the phenomenon.

2. Causal conditions for the application of the CG model in a relief setting

Without these causal conditions, the phenomenon would not exist. The question is therefore: “What led to the phenomenon?”

General observations

Every interviewed Medair staff or former Medair staff member expressed in some way appreciation for the CGs and all were convinced of the power (mainly regarding the strong network and high coverage) and the impact that the CG model has. All these statements culminated in the one of the Senior Health & Nutrition Advisor, declaring that the CG model is a regular feature of Medair’s work in protracted crises.

> If we think we're going to be doing multi-year programming in an area and not just like a six months thing, then this would be the type of approach we'd like to have in our proposals (Interview Emma).

Committed staff who have positive conviction about the value of the CR model seems to be one of the keys for the implementation and application of the CG model and is therefore considered as a general pre-condition for the phenomenon.

> So, definitely I would persevere when it’s hard at the beginning to continue to implement it (Interview Susan).

Several interviewees mentioned that setting up CGs shall be tied to a *long-term perspective* of the implementing organisation as it takes time and requires efforts on different levels. Otherwise an application of the CGs could be difficult.

> Like a CG has never been implemented I'll just recommend them to be patient. When you are developing, when they are setting up CGs, it would take you like six to seven months for you set up the CGs. So, they need to be patient (Interview Jacob).

Besides being patient as an organisation, the Medair staff also recommend being aware of the required steps for starting CGs and *thinking through before implementing*. This advice came from staff of different salary groups. The attitude of the implementing organisation seems to be crucial; and therefore it is seen as another general pre-condition for the phenomenon.

> And I would really think through before starting it and how it can work and not (.) (Interview Susan).

> So, whoever is organising a CG, they have to think through and plan before and considering the most effective ways to start it (Interview Evan).

The *involvement of the community* shall be mentioned as a last general causal condition for the application of CGs.

> I'd recommend that from the one who will start the CG that they involve the community– the ENTIRE community in every single bit. From the scratch, from voting volunteers, voting promoters, in every discussion the community should be involved. And this one helps a lot in promoting ownership, so that the community will not be feeling this is a Medair CG, they will feel, "This is our (.) concept, this our approach," and they will feel benefit (Interview Evan).

In both countries and on all project sites the community leaders, opinion leaders, and further local authorities were contacted and taken on board before starting to implement CGs. Only when the leaders acknowledged the CGs as an appropriate way to spread health and nutrition messages in their community, did Medair begin to implement the CG model.

> And starting for the CGs in Mogadishu– the first we started in community mobilisation as the initiation for the project activities. And meeting with the community elders, with the district commissioners, the chairmen of the districts (Interview Fatima).

One case was mentioned in an interview, when the community leaders felt overwhelmed by the big and strong network of the CGs and they decided to shut down the CGs in their community.

> […] the authorities, seeing it was working so well and how powerful it was, they kind of wanted us to stop, just because they were losing power over the community, because you can pass information very fast with it […] (Interview Susan).

It was the community leadership who decided about the CGs, although Medair encouraged them to take on the model.

> But it would be something that we would try to set up and encourage a community (Interview Emma).

For having a basis for discussion with the responsible party, and also for targeting the appropriate group of population for behaviour change messages, an assessment (for example: baseline survey) is recommended.

> […] it is always good to do a baseline, you know kind of an assessment, so that you can see how things are. Maybe like mortality is, how morbidity is, how the spread of diseases like diarrhoea is, like pneumonia, like how malnourished children are and share with the community at the beginning (Interview Evan).

Coming from the general causal conditions for applying the CG model, the next sections shall differentiate the two contexts of Somalia and South Sudan.

Somalia

The program context of Somalia served as a pilot project for Medair. Member organisations of the CORE Group[10] have implemented CGs in development settings and their results on the long-term impact on morbidity and mortality convinced Medair to set up the pilot project in the chronic crisis context of Somalia. The core topic at the beginning was Infant and Young Child Feeding (IYCF).

> […] there didn't seem to be huge differences between that and some of the chronic complex emergencies where Medair might be in a location for multiple years (Interview Emma).

The risk of using the CG model in a context other than originally designed for was rewarded with successful results and validated by an external evaluator.

> And with that evaluation we noticed a big change in just a year. So, it was a year after they started– I was a little bit worried about really measuring any change. It was a very short window of time, but what surprised me, was the changes in exclusive breast– it was exclusive breastfeeding (Interview Emma).

The *pilot project and its positive results* are therefore considered as a causal condition for the application of CGs in Somalia and finally in other countries of Medair's operation.

> […] we have proven that it can work in the Somaliland context, it could work in the South Sudan context and give us results which we struggled with previously (Interview Emma).

As already mentioned *involving the community leadership,* as a precondition for the implementation of the CG model, took place in Somalia. One of the interviewees described the process as follows:

> Normally we work with partners here. So, the partners and Medair staff and the local communities are jointly meet the district commissioners and after meeting with the top officials of the district, we further had a meeting with the official leaders and explain them of how the project, the CG project is implementing.
> And after that we introduced to them the community and whereby we informed them that every 15 households will nominate one female that will coordinate and provide health education messages to the rest of the 14 households and also for the household from his or her. So that is where we start– how we start in our

[10] More under http://www.coregroup.org

> context for the CG activity in Mogadishu and even the rural areas (Interview Fatima).

South Sudan

In South Sudan, the situation for starting the implementation of CGs was difficult due to an already existing approach where the health promoters were paid for their engagement. For the sake of common understanding and introducing the to-date unknown volunteer based model to local authorities, a workshop was held. This is one example of how *the community was approached* when introducing the CG model in South Sudan.

> The community leaders had to be involved in a workshop to enlighten them of the new approach. It was a bit difficult because we were putting off many incentive promoters and turning to a voluntary approach (Interview Daniel).

The *country's situation* was another causal condition for applying the CG model, although on a decision-making level. At the time Medair had chosen to expand the use of the CG model from Somalia to South Sudan, and the population of the latter faced a significant emergency level for nutrition. IYCF was a topic that affected the majority of families.

> […] everybody is receiving some IYCF, it was felt that we're going to build some– have to create a network to communicate that at the household level, then why not– why not add more sectors to that and actually come up with the concrete model like the CG model (Interview Laura).

In the above interview passage the *multisector idea* was already mentioned. In South Sudan, Medair implemented programs that included several sectors (for example: health, nutrition, WASH). One of the teams was designated to implement the structure of the CGs without providing the content of the lessons.

> […] a separate team that implemented just the model itself. So just making sure that the structure was there, the meetings were there, that they really understood the criteria and the approach of CGs. But the technical input for the content was provided through the sector leads, the team– the technical teams (Interview Laura).

This course of action safeguarded the proper implementation of the CG model and was considered by the researcher as a pre-condition for application of CGs.

3. Context of the “Application of the CG model in a relief setting”

The context poses questions regarding time, place and duration (Boehm 2003:272) of the application of the CG model and asks about attributes of the phenomenon.

Somalia

The CGs were implemented as a pilot project in 2010 in Somalia. Within Medair, Somalia was the first country of operation using CGs, which was also unique regarding the overall NGO activities in Somalia.

> […] we are the first organisation that was been created– who have been set up CGs in the country (Interview Ajib).

An attribute of the application of CGs in Somalia is it being a *long-term intervention* and in the case of Medair, a field-proven model.

In terms of the context where Medair applies the CGs in Somalia, both IDP settlements and rural communities are involved. When people flee, they assume they will return home within weeks or a few months at the most. The context of Somalia shows a different reality:

> […] because the chronic protracted conflict in Somalia made the people to stay somewhere for a long time and in a normal relief settings people are there for short. […] some of them have been in those camps for more than 10 years. That is in Mogadishu. So, we also have some other areas where we do CGs, in rural areas which are not camp settings (Interview Evan).

People in Somalia *are* moving, but because of their long residence in the camps or in settlement areas, the *population is semi-static*. The application of CGs is therefore possible and the semi-static population describes one aspect of the context in terms of duration and place.

South Sudan

In South Sudan, Medair has two project sites where CGs are being used. One is in Maban, where the model was introduced and implemented in 2015. The context in terms of place is the refugee camp “Yusuf Batil”.

> […] these very communities are in a refugee camp. We work in a refugee camp. And this refugee camp is having a population of almost 42’000 people (Interview Jacob).

Working with refugees in one place for *rarely shorter than months* brings advantages in applying the CG model. People are accessible and *more stationary*, though movement does happen.

> I think one reason for that is the kind of a controlled camp setting. We're able to more easily target the beneficiaries and it is just easier– like people are much closer together (Interview Len).

The second project site in South Sudan is Renk, where the implementation of CGs started at a similar time as in Maban, but the characteristics of the place are different. The settlements are not refugee camps, but IDP communities, that are spread out and in some cases *not yet static*.

> In Renk, so there the population is spread out over the whole county in different communities, in different places. […]
>
> So, in some areas people were just still hiding in the swamps but they could come out and be part of the group (Interview Laura).

The movement of people is, among other reasons, related to the place, as was stated in one of the interviews:

> During rainy seasons and harvest times women go to work in the fields and the number of attendance drops (Interview Daniel).

Besides harsh living conditions, the services in Renk are limited, which forces people to move or rely on the work of an NGO.

> There's not much– ja, there's just not much going on in Renk, like government services are extremely limited and Medair is one of the only NGOs (Interview Len).

One last characteristic of the application of CGs to be mentioned is the *cost effectiveness*. It was brought up by five out of nine interviewees, mainly from the staff working in South Sudan. The model is volunteer-based and the cascade structure makes possible broad coverage of the target group.

> But one great thing about the CG model was that it's a pretty cheap model. Like most of our budget is not spent on CGs, it's spent on other programs and projects. So, you can implement it for minimal resources (Interview Len).

4. Action and interactional strategies related to the application of the CG model in a relief setting

The action and interactional strategies are processes and at the same time goal-oriented (Boehm, 2003:272). The proper implementation of the CG criteria (see 2.4.2) with its different aspects turned out to be a key action strategy related to the application of the CG model. The CG criteria apply to both contexts, Somalia and South Sudan, and shall therefore be explored in direct comparison. If handled differently the cited interview passages will illustrate the "how", as well as additional action strategies for the CG criteria, found in the available data.

The *selection process of volunteers* is done either by local authorities or by the neighbourhood group itself. It is crucial that the selection be done by people who know the community and the interrelated connections.

> So, we want them to be able to be the ones who select, because if we select we might select somebody who is from a different clan, we might select somebody who they don't like and then they may refuse that person to visit them and to give health messages (Interview Evan).

Although Medair formulated some principles for who could become a CG volunteer, it was the community who selected them.

> […] we've had either the mothers in a certain area– you know after we do mapping, selecting who is going to be the leader in their houses or we've had some cultures where– you know, it's the chiefs or elders who say ok, for this area we want this person. And we prefer when the women themselves pick (Interview Emma).

> […] we segment the area into households, segment down to each ten to fifteen households. And then those ten to fifteen households we will ask them to select one person among them who will become a volunteer (Interview Evan).

In all project sites, the target group consists of pregnant or lactating women or mothers of children under 5. It is the aim to reduce their morbidity and mortality through the collective effort as a CG.

> So, from the beginning we explained to them that this is like just collective effort for us to make sure that we reduce the morbidity and the mortality among the group (Interview Jacob).

Since volunteers are key to the success of CGs, they need to be taken good care of. Their *workload should be appropriate* to a voluntary engagement. In the context of Somalia and South Sudan it is mainly the women who care for

the children and the household, for example: food scarcity as an effect of the protracted crisis requires increased efforts in their daily life.

> Maybe the mother, she has some small income outside of *[not understandable]* she manages that money to household, but the man or the husband have not do anything in the village and he cannot do anything for the management and cover the needs of family. So that's why mostly the ladies are dealing with the business and with other things so *[not understandable]* household (Interview Fatima).

A volunteer's responsibility is therefore ten to twelve neighbour households in the project context of South Sudan, and fifteen in Somalia. It brings two days of a weekly commitment from each volunteer as they must try to pass the message on to five to six households per week.

> […] they normally work for two days in a week. And for that two days they went to– at least to 5 households and give them the health and nutrition message. For every week for two days (Interview Fatima).

A lesson learnt from the pilot project in Somalia was that volunteers are limited in their time capacity. The idea was that the volunteer does the follow up or tracking after a neighbour woman has left a clinic but it turned out to be too many time-consuming responsibilities.

> I think it was far too much on their plate and they couldn't do everything. So, we didn't do that again (Interview Susan).

With a smaller size of the CG, the attendance can be monitored and *participatory learning* is possible. Medair tries to use more dialogues and discussions than didactic teaching.

> […] we focused a lot on what does it mean for women to actually learn and to adopt– you know, change behaviours, our goal and how reaching that rather than are we just showing messages (Interview Laura).

> You see the colour picture and you discuss what so you see in that picture, what *[not understandable]* is that all of them will get to discuss. Sometimes we put them in groups, pairs, you pair them, they discuss and they give feedback to the person who is the person who did it (Interview Jacob).

All the messages are illustrated with pictures, which makes it possible for even an illiterate volunteer to pass on the message learned. The volunteer meets the women of the neighbour households every other week and explains the monthly message to them.

> […] because of CGs we use pictures and photos that demonstrate measles, that demonstrates diarrhoea and that. And volunteers and promoters can easily explain (Interview Evan).

The teaching and discussion sessions from the promoter to the CG volunteers usually last for one to two hours. If there are practical demonstrations like cooking included, the teaching could take longer. These teaching sessions as well as the meeting of promoters with Medair staff take place monthly.

> So, whenever they give us the reports at the end of the month, we give them– or we sit down together– we did a monthly meeting discussing the last months implementation, the challenges, then we pay them the incentive (Interview Fatima).

The promoter also supervises the volunteers by means of a checklist:

> Have the messages been clearly understood? And how they deliver that health messages and communication– in terms of communication in household levels such a check list use help the promoters (Interview Ajib).

A *monthly coverage of at least 80%* of the targeted households is another CG criterion and at the same time an effective action strategy for application of the CG model. The context of a relief setting could however challenge the criterion of the coverage due to the living conditions of people.

> The CGs are effective in that they reach the women at the house-hold levels. At the moment, the coverage of the targeted groups ranges between 70 – 80% due to movement of women, agriculture seasons and women not found at their homes as they go for search of food for their children most of the time (Interview Daniel).

The coverage is also dependent on the distances that the volunteers must walk to the households for which they are responsible. For the sake of geographic proximity, Medair refused to accept volunteers from another community.

> So, these people they are from the different– they are from the other villages, which are not very near to this village. […] they cannot know what is immediately happening within the village. So, we refused to that thing […] (Interview Fatima).

Knowing what is happening within the community was particularly important when it came to *vital data collection* as another CG criterion. All the CGs collected data about births and deaths of children and mothers within their community, although the volunteers are mostly illiterate. The collected data serves a two-fold purpose. Firstly, it encourages the volunteers as they see the changes achieved through their commitment. Secondly, it serves as an important source of information for planning and adopting Medair's programs.

> I think it can be annoying to staff fill in the forms and data that CGs collect, but it's an amazing amount of data that we collect through the model, which is very helpful (Interview Len).

Getting the data collected by the volunteers was challenging due to their literacy level and as a result some adaptations were necessary. In Renk, South Sudan, the volunteers were capable of reading and writing and did some of the paperwork on their own; however, the volunteers in Maban were illiterate, but they had learned to record the numbers correctly on tally sheets.

In Somalia, the volunteers kept the occurrence of deaths and births in their head until a promoter who came to the village for supervision wrote down the information. The promoters are therefore more involved and visit the volunteers fortnightly.

> […] the promoter's responsibility is to go for that village and collect the data. And even the mothers they can understand and they can count the numbers of the people they are receiving the health and nutrition message, but they cannot write (Interview Fatima).

The *topics that are covered* in Medair's CGs were related to the core topic (reducing morbidity and mortality of pregnant and lactating women and children under five) and include the main sectors of activities: health, nutrition, and WASH. The aim is to close the gap between knowledge and practice.

> The CG model was designed to reduce morbidity and mortality and to reduce the gap between knowledge and practice (Interview Len).

Some examples of the topics covered by the messages include exclusive breastfeeding, preventable diseases and childhood diseases. As mentioned previously, the target group is pregnant and lactating women and mothers of children under 5. All topics are related to the target group and their children but there are also some topics related to circumstances.

> For example, if this month our team topic was on exclusive breastfeeding, but then there's an outbreak of Acute Watery Diarrhoea or Cholera, then we will make sure that we include Cholera prevention, treatment seeking, medicine, all that we include in our topics (Interview Evan).

> So, Malaria– there was a very bad Malaria outbreak in Maban, we focused a lot on Malaria prevention, but we didn't do that in Renk, because there wasn't so high level of Malaria. Things like that. It was more tailored to what the challenges were (Interview Laura).

Since there does not exist a fixed curriculum for CGs, Medair began to include messages about psychosocial support in South Sudan and about sexual- and gender-based violence in Somalia. It was felt to be a great need in both coun-

tries, because people experienced traumatic situations as a consequence of the protracted conflict.

Medair puts great value on customising the way the subjects are approached. Various experiences, especially in Maban, shows the importance of it (see table 5.2). The CG criteria also call for respecting the culture, the population and the volunteers.

> […] to understand how they associate and live among themselves is important (Interview Daniel).

Since women and children are the most vulnerable in the context of Somalia and South Sudan, even more attention needs to be given to their empowerment. CGs aim to *empower women*; and though this component is hard to quantify it is happening in various ways (see 6. Consequences of the action strategies for applying the CG model in a relief setting).

> And the last thing is the overall incentives in CGs– I mean it's just like a most overused term in the field, but it empowers women to– you know, to support each other. I mean– I think in general it is just sharing health and hygiene messages with each other, but I think there is also an unqualifiable resilience component, support component, empowerment component (Interview Len).

> CGs in a village is to empower the villagers. And by empowering the community, which means that we are giving the community in terms of knowledge, in terms of behaviour changes these are– that will continue with them long, long after Medair has left (Interview Evan).

Interestingly, in Somalia there are also men serving as CG volunteers delivering health and nutrition messages to the community. It does not seem to make a difference concerning the subjects covered and it appears that the neighbour women do not refuse to talk about topics related to their health with a man.

> H: Yes, we have men.
> D: Ok. That's interesting!
> H: Yes, but they are little.
> D: Are they also talking about the health of the children and breastfeeding or do they cover different topics?
> H: No, it is the same. They provide health and nutrition messages, for hygiene promotion, exclusive breastfeeding, save motherhood *[not understandable]* all other ladies they do.
> D: Ok, and the households they are ok if a man comes and talks about these issues?

> H: Yes, because of if the man comes from the other village, maybe they wouldn't accept. But if they are from the village and they are very near– the 15 households are very near. So, they know very well, they can talk, they can ask, they can share everything (Interview Fatima).

It is recommended to conduct *formative analysis as well as indicator-level evaluations* annually. Medair closely monitors and evaluates the progress and outcomes of CGs in all programs in either formal or informal ways.

> When looking at Maban, we have our survey results every six months and so we were looking at some of the key behaviours like exclusive breastfeeding, diarrhoea prevalence in under 5s, handwashing practices and latrine usage (Interview Laura).

> So, we often had to use informal barrier analysis instead, more focus group discussions or feedback through the CGs themselves to make sure that we were developing the right curriculum (Interview Laura).

> I mean, obviously we're not doing like Randomised Control Trials and it's not a purely scientific analysis, but in general like the trends are pretty clear– you know, and improvement of health, hygiene and nutrition indicators with the introduction of the CG model (Interview Len).

The results of evaluations encourage the volunteers because they see the outcomes of their efforts:

> It is always good to do a baseline, you know kind of an assessment, so that you can see how things are. Maybe like mortality is, how morbidity is, how the spread of diseases like diarrhoea is, like pneumonia, like how malnourished children are and share with the community at the beginning. And then with time as they implement the CG, probably after one year, come back to the community again do an assessment and show them what has happened (Interview Evan).

As a last point regarding the CG criteria, the *background of volunteers* shall be mentioned. Coming from the same community, speaking the same language and sharing the same education level supports good cooperation not only within the CG but also between the promoter and the volunteer.

> Yes, they were always part of the community, basically at the same level, education level, as the neighbours, because they were basically in the same area. In Somaliland, obviously everybody was Muslim. In some places in South Sudan they were also Muslim and maybe in another project they were Christian (Interview Susan).

In Maban, the population within the refugee camp is more homogenous. People come from the same area, speak the same language and have the same

culture. Mixing with other ethnic groups seems to be difficult and the volunteers would have to be part of the corresponding community.

> So, the women are meeting with the women that are around them, so you know– I guess typically that means you would congregate with people who are like-minded (Interview Len).

By contrast, in Renk the population is more heterogeneous, but the acceptance of a volunteer from a different ethnical background seems to be higher compared to Maban.

> In Renk that was a more cosmopolitan area or I should say mixed, so they are ethnically mixed and kind of religiously mixed sometimes. And at least the team said that it was no problem. In that area, it's ok to be mixed and people– we didn't have a challenge with the CG volunteers being not accepted by their group (Interview Laura).

A further strategic action, which is not directly related to the CG criteria, is the intention to *incorporate more men* into the CGs.

> And we're exploring that in some of these other cultures how do we tie in the men (Interview Emma).

This could be even more interesting since in the South Sudanese and the Somali cultures men seem to be the decision-makers.

> So, the refugee camp they have quite a strong local governance structure with Sheiks and the community leaders and so we really– first is focus group discussions and that with the MEN (Interview Laura).

5. Intervening conditions of the application of CGs in a relief setting

According to Boehm (2003:272), the intervening conditions are reasons for and underlying factors of the strategy, including the social, political and cultural environment, as well as individual biography. The aspect of individual biography was not directly applicable in this study, since the interviews were expert interviews and the personal background of the interviewees was not focused on.

An intervening condition is related to the context; the *challenge of using a volunteer-based model in a relief setting* and asking people for their commitment while knowing that they already struggle with providing for their families. It seems that the volunteers are proud to be part of a CG and the community respects them. Nevertheless, all field staff mentioned that they are frequently

asked for money or material incentives. In one of the CGs in South Sudan, some of the volunteers decided even to sell the plastic seats provided by Medair for the convenience of the group meetings. They felt no need for sitting on a chair and preferred to make some money out of the seats. Since the chairs did not belong to them, Medair had to act and discuss the situation with the volunteers and their community leaders. Although given the opportunity to leave the CG, all women decided to remain and continue volunteering for their neighbour women.

Volunteers are committed; however, because of the difficulties accessing food priorities are sometimes set differently.

> So, and you know that this person you are not paying them, so you cannot come for accountability. And we sometimes when you go to the household– when you go to the village, you can see that the mothers are absent here. For this one day or two days. So, the others of neighbour they said the two days the CG volunteers did not come for us. So, when you ask for them they say: “I have problem. I went to another district, because of my money.” So, they come with issues. So, you are most to accept what they said (Interview Fatima).

The economic context and the difficult living conditions of the volunteers require sensitivity when handling absentees.

> […] I know that at least in relief contexts understandably a lot of people say: “Look, I've got other priorities I need to be working on.” I think especially there were times of the year getting people to still meet regularly– it is understandable if they don't want to meet, because there's a food distribution. They need to go for that (Interview Laura).

The encouragement of volunteers is a task of the promoters and they in turn are supervised and supported by Medair staff. Working with dedicated and motivated volunteers and promoters is important because they are key to the success of CGs.

> […] the promotors especially, because they're key part of the success of the project (Interview Len).

The protracted conflict situation as well as seasonal conditions cause *people-movement*. This is an intervening condition on different levels. Firstly, Medair as the implementing organisation is not able to rely on the mapping done before setting up the CGs for long. The mapping does not reflect the community’s situation over the long-term, and must be redone after a while. This increases the workload of Medair staff.

> So, we would– so mapping even at the beginning can be difficult when– I would say in the refugee camp in Maban is not such a problem, but in Renk where the population is more disbursed, it's a really big issue. And just map and understand who is there and are you getting the right coverage, is everyone coming out is quite difficult (Interview Laura).

Secondly, meeting the coverage of 80% of the household monthly can be challenging because of people-movement.

> Because everyone is more disbursed so it is a little harder on the mapping side to see if we really had 80% at least coverage of the target population (Interview Laura).

Somalia

A specific example of problems faced by the CG volunteers in Somalia is the *recurring food insecurity*. It is an underlying factor of whether the women are capable of putting the received messages into practice or not.

> For example, since last year there has been severe drought in Somalia. And we still try to encourage mothers to do exclusive breastfeeding. But then the mothers will come and tell us: “Yes, you are telling us to do exclusive breastfeeding and we don't have food” (Interview Evan).

Linked with the political context is the *issue of insecurity*. In Somalia, the CGs seem to be affected mainly in one location. Medair staff are not able to travel there and they do the supervision *in situ*. The data collection and the supervision is done by phone.

> Except in the areas of insecurity places. Like insecurity places we normally recorded all the list of the volunteers by name and the contact numbers. […] Then direct communicating with them by calling their personal phone numbers, and interviewing and asking all our indicators from our target or what we– what they do (Interview Fatima).

Another consequence of insecurity is that storing the materials (for example: soap; t-shirts; umbrellas, etc.) that are given to the volunteers as a yearly reward seems to be a challenge in some places.

> […] in distribution of that reward we have much of problems with the community leaders or some people who live in the village. And also, we have some issues about in terms of handling these materials in terms of security (Interview Ajib).

Another influential intervening condition is that *volunteering as such is not known* in Somalia.

> […] volunteering to the community freely is something very new (Interview Ajib).

Medair and its partners first need to explain about volunteering in general before the CG model can be introduced. Illustrated by past experiences, Medair tries to explain the benefits of voluntary commitment for the whole community, as the statement of a South Sudan staff member explains:

> So, from the beginning we explained to them that this is like just collective effort for us to make sure that we reduce the morbidity and the mortality among the group. So, we explained to them, it is just like you are helping your family and you have really to make sure that help (Interview Jacob).

Two different interviewees mentioned *traditional Somali beliefs* which are related to core topics of Medair's curriculum for the CGs. One aspect is the health seeking behaviour. It seems that people in Somalia trust more in the abilities of traditional healers than in health centres.

> In Somalia, they mostly using the traditional healers. So, they are not coming to the health centres. But now they *[not understandable]* different from the previous years. The most thing is that they did the people understanding that health centre can get for some treatment, health and nutrition messages, counselling, everything from the health centres (Interview Fatima).

The second example of cultural convictions as an intervening condition to action strategies in Somalia is related to breastfeeding. Women think that:

> […] if you breastfeed then your breasts are going to be all damaged and then your husband is going to take another wife (Interview Susan).

As a way of managing the intervening conditions related to culture the CG model encourages volunteers to become a role model for the community.

> We first persuading the CG to exclusive– to give excluding breastfeeding for six months the child, with no water and milk. The first month they was not accepting for us. But after we give them more training, more support and supervision and clarification, they accept for the volunteers. So, within the volunteers they started to give exclusive breastfeeding for their children (Interview Fatima).

As the CG volunteers discover the effects of their changed behaviour (in this example they discover the benefits of exclusive breastfeeding) they pave the way for other health and nutrition messages to be listened to. Otherwise the cultural beliefs may be too strong and become a hindering intervening condition.

South Sudan

As in Somalia, *insecurity* also affects the work of Medair in South Sudan, although it should be differentiated between Maban and Renk. Whereas in Renk constant insecurity hinders the women's meetings from time to time, the uncertainty in Maban is more connected to ethnic aspects.

> You know, Renk will have periods of insecurity and maybe the team has to hunker down or send a few people out maybe once or twice a year, something (Interview Emma).

> Insecurity affects meetings that they don't happen. But in Maban were recently some tensions in one of the camps and UNHCR has basically moved some members of a certain ethnic group to do another camp so that there– so that CGs are basically segregating (Interview Len).

This leads to a further intervening condition: first getting to know the culture and *respecting the culture* when applying the CG model (see also table 5.2).

> Knowing the cultural background of the community is an advantage for effective implementation of the CGs (Interview Daniel).

The commitment of volunteers and their encouragement was already mentioned as a factor for the successful implementation of CGs but just as important is the backing through Medair staff and their efforts in applying the CG model. The staff not only have to be committed to the CG model but they must be convinced about its usefulness and appropriateness as a precondition to the phenomenon. Likewise, it seems to be a supportive intervening condition if at least one person or even a team is fully *dedicated to the application of the CG model*.

> […] in a relief setting even more so than in any other context, it is key to have at least one person (with some support from somewhere) who passionately believe in the concept and has seen it work (Interview Susan).

> […] so it was actually a separate team that implemented just the model itself. So just making sure, that the structure was there, the meetings were there, that they really understood the criteria and the approach of CGs (Interview Laura).

6. <u>Consequences of the action strategies for applying the CG model in a relief setting</u>

Some of the consequences of previously outlined action strategies for applying the CG model in a relief setting can be anticipated, others are unpredicta-

ble. When the CG model is implemented, specific results are sought. For example, when giving messages about exclusive breastfeeding, the expected outcome is that women do exclusively breastfeed their children. This did happen in both project contexts, Somalia and South Sudan, as the figures in evaluations and surveys proved.

> […] we've seen it go from 55%, as our baseline, which is quite low, to almost 100%. I think it's gone down just a little bit in recent months, but in general it's like– I think it's well over 90%. So, to go from 55 to over 90% is very dramatic and a huge success story. Same thing with hand washing practices, we've seen it go from 27 to 74%, diarrhoea prevalence we've seen it go from over 50% to like 17% (Interview Len).

Soon after women started to practise their newly gained knowledge as they had already seen some results:

> So, you can see after six months the ones who exclusively breastfed, the babies were very fat and the one who don't exclusively breastfed don't. You know, get sick and with all those things (Interview Susan).

Besides the hard facts in terms of numbers and percentages of changed behaviour, there is the aspect of volunteers being a *role model for the community*. The volunteers gain respect within the community and they have an impact on how the health and nutrition messages are being understood and executed.

> […] the volunteers are now being like examples who in the community exclusive breastfeed their children, now also their neighbours are copying from them. But now, what has– what we also realised; there is a very great reduction in terms of morbidity and mortality just within the camp (Interview Jacob).

Having volunteers who belong to the community and commit themselves to supporting the community has an impact that goes beyond changed behaviours. The consequence of women feeling part of the community because they were taken seriously and paid respect, leads to *social changes*, as the statement from Somalia shows.

> Before now, women have no role in the community in terms of decision making and all the– all levels of the authority in the community. They have no more– activities in the community level. But now, these CG seems to they are strengthening women and taking power to the women. Because of they are taking a crucial role in terms of the community. And most of the women are now feel to be a part of the community (Interview Ajib).

> […] this really gave them a voice they didn't have before. So even though they were still illiterate and (.) sometimes very young mothers, very powerless they

had reflected to our staff that they felt that this gave them a lot of honour and status (Interview Laura).

The action strategy of customising the health, nutrition, and WASH messages to the respective context also contributes to the success of the CG model. As a consequence women are ready to listen to the lessons provided they relate to their culture. Combined with the personally experienced benefits of changed behaviour in the life of the volunteer, it leads to consequences on different levels which are not measurable throughout (for example: strengthened relationships). *Key outputs* related to the topics covered in the CGs were stated in the interviews such as:

- Reduced childhood diseases (for example: diarrhoea, measles)
- Reduced pregnancy related deaths of women
- Increased birth delivery at the health centre or hospital instead of at home
- Increased latrine usage instead of open defecation
- Increased hand washing practices

> […] when looking at Maban, we have our survey results every six months and so we were looking at some of the key behaviours like exclusive breastfeeding, diarrhoea prevalence in under 5s, handwashing practices and latrine usage. Maybe these were some of the key activities and a few others. They are certainly– I can't say that it was completely based on the CG model, but if you look from 2014 to 2017, we introduced the CG model in late 2015, and there's quite a jump from– in some of those behaviours up to 40% increase in practice, in positive long-lasting practice (Interview Laura).

A further consequence, mentioned by staff members in Somalia and in South Sudan is the *strong and wide network* that the CGs build. Within a few days a message can be spread. This is especially advantageous if a disease breaks out in addition to the daily challenges of living in a protracted crises situation. The available network allows Medair to react timeously and advise people in terms of prevention or advice concerning their behaviour in case an infection had already happened.

> We are also able to respond timely in case there is any outbreak of a disease, for example Acute Watery Diarrhoea. And, you know, it follows this chain of information where we can spread a lot of information within a very short time (Interview Evan).

> I think also in this context, in a relief context, it is quite useful to have the network. The fact that we could quite quickly communicate with a lot of people and have a communication done through– you know, through a local woman, women to women, the peer-to-peer concept– so it's quite useful when we had acute conditions like the Malaria outbreak or the Cholera outbreak. And it was a really helpful way that we could communicate quickly with– you know, in our case maybe 5000, 6000 households and know that within a week everybody got at least to hear some of those messages (Interview Laura).

"Powerful" or "strong" were some of the attributes that the CG model was described as by the interviewees. Their description related to this broad and well-functioning network.

Spreading messages is one part of the well-functioning network. The other part is the data or information collected by the volunteers that allows Medair to target a specific community or only an area of the community with the needed information. Since Medair works with multi-sector programming, the respective team is, therefore, able to react to incidents related to their expertise.

> So, in that way we were able to link across the sectors well, so when we would see (.) more people with increased diarrheal incidents then they could tell the WASH team: "Hey, you know, in this region, in this CG they're having a much bigger problem. Can you go and check their water resource?" And we could link in like that.
> Same with the one clinic which was suddenly to see increasing Malaria. They could send a message through that CG and say specifically target: "Hey we're having a Malaria outbreak; can you bring a message into this target area?" So that helped, I think, with the response, with the issues quite well and linking across the three sectors (Interview Laura).

Collecting the data and sharing the results of the analysis with the community leaders as well as with the volunteers influences their motivation for the CGs. They can recognise the impact of their commitment on the lives of the community members, based on surveys and evaluations.

> And the best motivation for them is when they see positive outcomes or outputs from what they have done. For example, if they see that the number of diarrhoea, the number of deaths, maternal deaths have gone down they feel proud and that's a very very big motivation (Interview Evan).

A major consequence of the action strategies the interviewees referred to was the *empowerment of the volunteers and the community* where they served.

> Is all about empowering the community, so whether we are there or we are not they know how to help themselves (Interview Jacob).

> […] there is also an unqualifiable resilience component, support component, empowerment component (Interview Len).

The CG model aims to bring knowledge to the people which they can put into practice. The experiences are shared with their neighbours. The knowledge as well as the relationships within the community are aspects of how the communities are being empowered.

> […] even when we don't have the perfect model and we don't get to run it for many many years, like in the classic development context, there is still that knowledge is taken with them (Interview Laura).

> […] because the community in a relief setting is all what's left and relationships and it's the main valuable resource for each other for them and for everyone. So– ja, I would definitely say it's a good– it's an excellent model to also– for the society to survive and get over the tragedy they are in (Interview Susan).

> The volunteers are community resources are– these people continue to stay in the community, they belong to the community, they belong to the household and they continue with what they are doing way after Medair has left (Interview Evan).

In one community, the Medair team experienced how women became creative and were willing to learn more. As a CG, they hired an English tutor and after the CG session finished they took English lessons. The relationships built through the CG were strong and the women felt connected and inspired and so the group benefited even more through their own initiative.

In Somalia as well as in South Sudan, CGs became a bridge within the communities. One South Sudan staff member stated that it brought "co-existence" to the community, and a staff member of Somalia saw the benefit of breaking a negative pattern related to decades of conflict:

> When built the CG, it been started social interaction, which support– which support in the peace. And also, social trust because in the last 20 years it's a lot– social trust in the community has been lost (Interview Ajib).

For other volunteers, especially in Renk county, belonging to a CG gave them a sense of purpose and structure even though their life was negatively impacted by the protracted conflict situation.

> So, in some areas people were just still hiding in the swamps but they could come out and be part of the group and– ja, a lot of the women said it gave them something that they valued […] (Interview Laura).

Medair realised the need for basic psychosocial support for the women and had experienced that the relationships built and the atmosphere of trust within the CGs could serve as a basis for such.

> […] but actually, something a little bit more linked to their dignity and psychological wellbeing (Interview Laura).

Sustainability of both the CG structure as well as the changed behaviour shall be looked at as the last consequence of the action strategies.

Changed behaviour has a sustainable impact on the lives of the CG volunteers and their neighbour women who also increase their knowledge about health, nutrition and WASH. Gained knowledge does not get lost even if the women have to flee again or if a refugee or IDP women returns to her home place.

> […] even the women themselves reflected and said: "Knowledge and behaviour change we take with us. We can't take the health clinic, we can't take the wealth, but we do take this knowledge", and– I mean I think you are already believing in it in a sense that the ultimate improved behaviour is one of the most powerful preventative practices that we can provide (Interview Laura).

These "preventative practices" in combination with the previously outlined impact the participation in a CG has on the status of a CG volunteer in her community, led to empowerment. Empowerment is a long-term output that is not dependent on whether Medair will continue supporting CGs or if the organisation will move on.

> […] by empowering the community, which means that we are giving the community in terms of knowledge, in terms of behaviour changes these are– that will continue with them long, long after Medair has left. The knowledge that those people who are in camp settings or relief settings are getting means that even if they move from one area to another they will continue *[not understandable]*. For example, if we say somebody knows how to treat a child with having diarrhoea with ORS are– and ensuring that the child this drinks, you know that mother will make sure– will continue with that knowledge ways after Medair has gone (Interview Evan).

For fostering the sustainability of the CG structure, Medair works in Somalia with two local NGOs. One employee of each organisation is being trained as a Community Health Supervisor and serves as the focal point for CGs.

> And this person works with us every day, comes to the office and so he or she understands entirely what we do. If we move out today, the whole programming aspects, the management, the supervision, the data collection at the end of the month, all those can continue because there is somebody from the local partner

> who understands entirely. So, in terms of structures, of management, that person is there (Interview Evan).

Besides the close collaboration with the two local NGOs, the basis of the CG is anchored in the community by means of the community health committee. The latter was established when introducing the CG model to the community, and it enables the continuation of CGs on-location even after Medair had withdrawn.

In South Sudan, discussions about handing over the CGs in Yusuf Batil Camp, Maban, to another international NGO are still in process.

Also contributing to the sustainability of the CG structure is the volunteering aspect. This was mentioned by different interviewees. It seems to be more likely that CGs continue because the volunteers' engagement is not dependent on a financial income but based on their decision to serve the community.

> And that's where having it been volunteers versus paid workers make it more likely to continue, whereas if they were paid, then usually– you know, people want to stop because the pay stops (Interview Emma).

Summary of key findings during the Axial Coding process

Table 5.3 below contains a summary of the previously outlined findings of the axial coding process. At the same time, it shows the above described differences of the application of the CG model in Somalia and South Sudan at a glance.

TABLE 5.3: SUMMARY OF FINDINGS OF AXIAL CODING

SOMALIA	SOUTH SUDAN
PHENOMENON	
Application of the CG model in a relief setting	Application of the CG model in a relief setting
CAUSAL CONDITIONS	
○ Involvement of the community/the local leadership at the beginning ○ Committed Medair staff members ○ Long-term perspective ○ Solid planning before starting ○ Pilot project	○ Involvement of the community/the local leadership at the beginning ○ Committed Medair staff members; a team designated to implement the structure of the CG model ○ Long-term perspective ○ Solid planning before starting

	○ Emergency level for nutrition ○ Multisector programming
CONTEXT	
○ First country of operation of Medair implementing the CG model ○ IDP settlements and rural communities; semi-static population ○ Cost-effectiveness	○ Refugee camp in Maban; stable population within the camp ○ IDP settlements in Renk; harsh living conditions; therefore, moving population ○ Cost-effectiveness
ACTION & INTERACTIONAL STRATEGIES	
○ Community/ neighbourhood selects volunteers Target: to reduce the morbidity and mortality of pregnant or lactating women and children under 5 → topics are all related to that aim, but also adapted to circumstances (for example: Cholera outbreak) ○ Volunteers are key to success; appropriate workload, encouragement, supervision, similar background and education level ○ Customised and illustrated messages ○ Maintenance of a coverage of 80% of the targeted households per month ○ Data collection; encouragement for volunteers and feedback mechanism for Medair ○ Empowering women → small number of male volunteers ○ Monitoring of the process; evaluations conducted regularly	○ Community/ neighbourhood selects volunteers ○ Target: to reduce the morbidity and mortality of pregnant or lactating women and children under 5 → topics are all related to that aim, but also adapted to circumstances (for example: Malaria outbreak) → psychosocial support added ○ Volunteers are key to success; appropriate workload, encouragement, supervision, similar background and education level → Maban: no mix between ethnic groups → Renk: mix between ethnic groups seems to work ○ Customised and illustrated messages ○ Maintenance of a coverage of 80% of the targeted households per month ○ Data collection; encouragement for volunteers and feedback mechanism for Medair ○ Empowering women ○ Monitoring of the process; evaluations conducted every six months
INTERVENING CONDITIONS	
○ Poverty and food scarcity leading to population movement ○ Conflict related insecurity ○ Volunteering is new to the culture ○ Backing through Medair staff ○ Traditional convictions concerning, for example: for example: health seeking behaviour; breastfeeding	○ Poverty and food scarcity leading to population movement; in Renk seasonal movement ○ Conflict related insecurity ○ Volunteering is new to the culture ○ Backing through Medair staff
CONSEQUENCES	

○ Success in terms of outcomes (for example: exclusive breastfeeding) ○ Volunteers being a respected role model for the community ○ Strong network; short reaction time in case of a disease outbreak; may concern local authorities ○ Empowerment of volunteers in terms of knowledge, which is mobile ○ Social interaction and social trust is being built ○ Sustainability in terms of structure of the CG model; and in terms of changed behaviour	○ Success in terms of outcomes (for example: exclusive breastfeeding) ○ Volunteers being a respected role model for the community ○ Strong network; short reaction time in case of a disease outbreak ○ Empowerment of volunteers in terms of knowledge, which is mobile; inspiration for the women (English classes) ○ Social bonds are being built within the community ○ Sustainability in terms of structure of the CG model; and in terms of changed behaviour

5.1.3 Process and results of Selective Coding

Continuing the axial coding process, the researcher analysed all categories developed during the axial coding and defined the essence of each paradigm code. This was done on a more abstract level, aiming to include all important aspects of a paradigm code and putting them into relation to the research objective. Comparing the essence of the respective paradigm code with the results of the open coding process complemented the selective coding.

Since the available research is an analysis of the application of the CG model, the researcher did not aim to find a single core category. Instead, she used the selective coding process to gain a more focused picture of the application of the CG model in a relief context. The data gained through the interviews was triangulated by various documents as a next step after the selective coding process.

Essence of the phenomenon

The phenomenon “Applying the CG model in a relief setting” did not change when analysing the expert interviews in the axial coding process: its essence shall be explained now.

The attitude of the interviewed Medair staff members was significant in terms of backing the CG model. Throughout the interviews they recommended working with the model, although they gave qualifications for certain aspects. The attributes the interviewee used for the CG model were, for example, “life-

saving", "excellent model", "strong tool". A total of 15 open codes were related to the positive attitude of experts towards the model and their conviction of its impact. Their working experience revealed how the output goes beyond the successes of changed behaviour in the areas of health and nutrition. They saw relationships developing in communities where social trust had been lost for years. They saw changed attitudes of community leaders towards the volunteers in terms of respect. They saw inspired women who wanted to learn English and they saw the CGs being a safe place for traumatised women, and so on.

Nevertheless, Medair staff were not unrealistic and pointed out challenges they have in working with the CGs. It may, for example, create tension as a result of setting up a volunteer-based model in a context where people live in extreme poverty and are not getting paid. Furthermore, population movement due to the conflict situation or seasonal food scarcity makes regular meetings difficult. Some challenges are related to prevalent cultural beliefs and behaviours; and, conducting formal analysis was challenging for an already capacity-stretched team, and so on. Summarised: the essence of the phenomenon could be defined as "successes *and* challenges" of applying the CG model in a relief setting.

Essence of causal conditions

After perusing the categories developed through the open coding that were deductively compiled into the coding paradigm during the axial coding, a variety of codes became relevant. These can be summarized with the generic term "concept". A causal condition for the application of the CG model in a relief setting, indicated by three different statements, was the solid planning of the implementation of the CG model. The experts emphasised that thinking through the implementation before starting allows them to anticipate potential challenges or makes the implementing organisation aware of inevitable difficulties involved in preventing a threat of a breakdown of the project. The "concept" also implies cognizance of a long-term perspective which is the nature of the CG model, for example: behaviour change requires perseverance and a long period of time. It implies the question of when and how the local

authorities and the community are being involved. In particular, the latter is an important factor for the successful implementation and the application of the CG model and therefore the open coding resulted in 32 codes about the involvement of the local community from the beginning, split into Somalia and South Sudan.

Essence of the context

Medair works in local communities and IDP settlements in both Somalia and in South Sudan, as well as in a refugee camp in South Sudan. All these forms of community living in a protracted crisis have a semi-static population in common. The semi-static population is a characteristic of the phenomenon and has a significant influence on the application of the CG model. Since the people's movements or the stability of a community was mentioned throughout all interviews, the researcher decided on "semi-static population" as the essence of the context. It seems to be a major challenge when using the CG model in a relief context.

Essence of action and interactional strategies

During the open coding, the different CG criteria were divided into various categories that were then defined as action strategies during the axial coding. When reflecting upon the paradigm code "action and interactional strategies" during the selective coding, the CG criteria are again brought together as the essence and named as "original design". The implementation according to the CG criteria is the foundation of the success of the CG model. The open coding category "Operation of CG" contained by far the highest number of codes (161), and is crucial for answering the research objective (4).

Essence of intervening conditions

As expressed in all interviews, the CG volunteers play a crucial role when implementing and applying the CG model. A major part of the success of the model is related to the volunteers and their commitment. The latter, however, is dependent on the circumstances the volunteers are living in. As outlined by different expert statements, food scarcity due to the protracted crisis affects the volunteers and their capacity to serve the community. Also, insecurity

caused by the conflict situation influences the meetings of the CGs and, in a broader sense, the volunteer's commitment.

All interviewees expressed their appreciation for the CG model and emphasised its power and impact when applied. Besides the volunteer's commitment, the staff member's commitment contributes to the success of the CG model. Thus, "commitment" was formulated as the essence of the intervening conditions.

Essence of consequences

The paradigm code of consequences of the application of the CG model in a relief context contained mainly statements concerning either 'empowerment' or 'sustainability'. Since empowerment implies sustainability, the researcher decided on "empowerment" as the essence of consequences. It is considered to be a strong argument for the application of the CG model in a relief setting because it has an impact on the participants in terms of psychosocial support even when the topic is not explicitly talked about. The relationships within the group, however, seem to be an anchor (to some extent) for the traumatised women and give them a safe place for mutual learning. These bonds contribute to the sustainability of changed behaviours as well as to the continuation of meetings, even should Medair withdraw.

As the next and at the same time last step of the data analysis, a broad variety of documents made available by Medair, was looked at. Triangulating the findings of the coding processes was the focus. Due to the researcher's life situation and the insecurity in South Sudan and Somalia, the triangulation was not made by a Focus Group Discussion or observant participation *in situ*; however, the variety of documents contributed to a broad picture and a valid triangulation of data. Moreover, the different roles, tasks and cultural backgrounds of the interviewees as well as their individual experience of the very same process also contributed to the triangulation.

5.2 Triangulation process

The available Medair documents were predominantly of a quantitative nature. The researcher separated the documents by country and imported them into

the software MAXQDA12. The same was done with the code system that was already developed during the open coding process of the interviews. The researcher analysed the documents deductively according to the defined categories and wrote memos where new findings occurred thereby leaving space for inductively developing new codes.

Some of the documents were not coded or only marked with a few codes. This was due to the content. Some reports and surveys were produced by external organisations (for example: UNHCR) which gave the researcher an overview about the project area and a more detailed view about the involvement of further international organisations; however, these reports did not give explicit information about Medair's work with the CG model.

Since Medair integrates the CG model in a multi-sector programming, the evaluations and surveys were not solely analysing the CGs, although parts of the documents acknowledged the performance of CGs. Nevertheless, the surveys allowed the researcher to comprehend and reconstruct the path towards the implementation of the CG model. Furthermore, the surveys illuminated how the theory was put into practice.

5.2.1 Analysis of documents concerning the context of Somalia

The open coding process of twelve documents related to the Somalian project lead to a total of 183 codes and 16 memos. As figure 5.4 shows, the codes are mostly connected with categories concerning the "Reason for working with CGs", "Operation of CG", "Topics covered", "Partners", and "Output of CG". This is not altogether surprising since these are core elements of donor funding proposals or reports respectively.

	Category	Code	No of Codings
●	Involvement of the community at the beginning	SOM	7
●	Reason for working with CG	SOM	20
●	Target group/Volunteers	SOM	0
●		section of population	3
●		culture	2
●		religious & educational background	2
●	Recommendations	concerning NGO's attitude	4
●	Recommendations	concerning CG criteria	3
●	Recommendations	concerning the context	4
●	Operation of CG	SOM	0
●		Formal & informal analysis	3
●		Participation (Start)	2
●		Coverage & information flow	1
●		Meetings	2
●		Teaching	5
●		Data collection	4
●		Promoters and their tasks	5
●		Volunteers and their tasks	14
●		Organisation of CG & Numbers	3
●	Program activities beside CG	SOM	3
●	Partners	SOM	14
●	Sustainability of CG	SOM	8
●	Topics covered in CG	SOM	12
●	Cultural context	SOM	2
●	Project context	SOM	6
●	Political context	SOM	3
●	Challenges of using CG	SOM	0
●		Consequences of relief setting	8
●		Workload, responsibilities	1
●		Culture	7
●		no payment (volunteering)	3
●	Impact of CG	SOM	1
●	Key aspects	SOM	9
●	Success	SOM	1
●	Output of CG	SOM	21

FIGURE 5.5: RESULTS OPEN CODING OF DOCUMENTS (SOM)

Key findings of how the content of the analysed documents complemented, clarified, brought further insights and, therefore, triangulated the interview data, shall be outlined hereafter. For the sake of a clear presenting structure, the categories clustered during the axial coding as well as the essence of each paradigm (selective coding) served as the concept.

Applying the CG model in a relief setting

In different documents, Medair outlines the benefits that the organisation experiences in using CGs. Some of the benefits are at the same time outcomes that will be focused on in a following section. Not all benefits rely on Medair's direct input, but on the CGs' own dynamic, as stated in the passage below.

> […] but very importantly, the group's own dynamics will be the key determinant in its efficiency. The ultimately goal is to facilitate the establishment of a support group-like atmosphere that allows for free expression and mutual support to flow (Medair 2014a:20).

The household-focused CG model seems to correspond with an emergency context in terms of insecurity.

> Services will be provided as close as possible to the beneficiaries reducing the risk involved in travelling. The Care Group Model further optimizes protection by bringing services to the household level (Medair 2014a:14).

The volunteers as member of the communities and their proximity to the neighbour households is an advantage for security issues since no travelling is required for sharing the health and nutrition messages. The core activities (household visits) take place in the homes of the neighbour women, which is a powerful method (Medair 2014a:24). Additionally, the organisation gets to know what is happening in and around the community which can, for example, be crucial in a crisis situation when deciding about the evacuation of personnel.

> Community health education can also be a key strategy to anchor an early warning system at the grassroots level (Medair 2014a:10).

Causal conditions

The documents gave insights into the organisational process of the CGs. Starting with a pilot project and seeing appealing results after only a year led to a broader roll out of the model in Somalia, and finally to the implementation in two more countries of operation by Medair. Due to these appealing results, the CG model became the standard concept when Medair intends to work on behaviour change in a multi-year program.

The required *long-term perspective* when working with the CG model was found in various documents, either as a recommendation (survey) or as an intention (funding proposal) of the program. Medair's multi-sector approach was also found. The evaluation of the pilot project recommended introducing the CG model as a *cross cutting strategy* through all the sectors (health, nutrition, WASH) (Medair 2012:6). In the context where Medair is implementing programs *time* is an important factor and it is stated that the multi-sector approach could enhance the effectiveness of the CG model in terms of changed behaviour.

> Being implemented as a component of a larger health, nutrition and WASH project provided the context by which to achieve positive behaviour change in a relatively short amount of time (Medair 2012:19).

The previous analysis of the interviews showed that Medair implemented the above-mentioned recommendation and the latter was proven right by the practice and the subsequent results (see for example: Interview Laura).

Since a pre-condition for applying the CG model is the *involvement of the local community and its leaders*, the researcher found several document passages confirming the in-interview emphasised importance of participation.

> Medair will also pursue feedback from community leaders and other stakeholders, as they are identified and willing to share their insight, they will be invited to attend and oversee Care Group activities. The expected outcome of this initiative would be an increase local ownership, and consequently, a more sustainable Care Group strategy (Medair 2014a:25).

The community leaders appreciated the outcomes of the CG activities in terms of increasing community health. This was already the case during the pilot project as well as in the succession projects and is considered a key causal condition for applying the CG model.

> Generally, the community leaders are aware of the CG project, the messages promoted and could identify positive changes in the community they attributed to the CG project. This support is key in encouraging behaviour change at a community level (Medair 2012:11).

As a last causal condition for the application of the CG model in the working context of Medair, the results of the *pilot project* shall be mentioned. As stated in the interview, the Senior Health and Nutrition Advisor was ready to take the risk and implement a model in Somalia that was then completely unknown to Medair. The results surprised her and thus led to further implementation and a high appreciation of the CG model.

> Despite the Care Group model being implemented for only one year there was strong qualitative evidence of increased knowledge and behaviour change especially regarding improved breastfeeding practises (Medair 2012:15).

Context

The pilot project took place in the northern part of Somalia (Somaliland), and today's CGs are mainly located in and around Mogadishu. Rural communities and IDPs were the target group. Before starting the CGs in these areas, a baseline survey was conducted in 2013, and it was found that the host communities were even more challenged in their access to services.

> Areas within Mogadishu that have a high concentration of IDPs have higher coverage in terms of health and nutrition services than host communities according to the WHO health cluster matrix. Host communities are less well served in Mogadishu (Medair 2013b:1).

Due to the protracted crises of about 25 years, most of the IDP settlements or camps had in the meantime been converted in permanent dwellings, as mentioned in the pre-interview questionnaire. Nevertheless, the CGs in the context of Somalia were still often confronted with *people's movement*. "Constant displacement owing to clan fighting" was given in the pre-interview questionnaire as one of the underlying factors that lead to *insecurity*.

> No people from outside the village can travel to the village (Medair 2015f:3).

Concerning the context, the analysed documents did not reveal new aspects but broadened the picture of the country's political situation and confirmed the essence of the category as "semi-static population".

Action and interactional strategies

The donor funding proposals were primary in giving an insight into how Medair implemented and executed the CG criteria, and the pre-interview questionnaire further complemented the findings. Since no contradiction was found in the interview data, not all the criteria shall be listed and examined here again. The researcher decided, therefore, only to focus on the criteria that were strongly emphasized in the documents. One of the accentuated aspects was Medair's *partnership with local NGOs* (total of 14 codes) in which they aimed to build their capacity in order to hand over the program, as well as dealing with security constraints.

> Given the security constraints in Somalia, Medair relies on partnerships with local NGOs for this access to beneficiaries, and on its national staff for regular support and supervision. International staff is also able to visit the health facilities on more limited basis under strict security measures. Because of this, Medair will invest on building a strong collaboration with its national partners (Medair 2014a:25).

The answer given in the pre-interview questionnaire confirms Medair's transition and exit strategy and its efforts in building capacity of the national partner NGOs.

Further, the CG criteria require that the *selection of promoters and volunteers* is done by the community and its leaders respectively. The process is documented and explained in funding proposals and in evaluation reports, as the example below shall illustrate:

> After these staffs are in place, they will support the recruitment of Promoters. To accomplish this, they will identify and meet with community stakeholders in their designated districts to obtain input on potential candidates. Once Promoters are recruited and trained, Facilitators and Promoters will repeat the process of community engagement to identify potential Care Group Volunteers (Medair 2014a:21).

The tasks and responsibilities of promoters and volunteers are outlined in several documents and do not differ from what was found in the interviews. Medair staff are required to care for the promoters and encourage and motivate them (Medair 2014a:20) since the promoters are key to the success of the CGs, as previously stated in interviews. Promoters are paid an incentive, and they teach and monitor volunteers and their activities, such as household visits or the collection of vital data (Medair 2012:9). The degree of a promoter's involvement in the latter is related to the education level of volunteers. If the volunteers are literate then the promoter compiled the data and handed it to Medair staff. If the volunteers are illiterate the promoter is much more involved in the data collection. The baseline survey report 2013 found the following facts about the people's education in the project area in Somalia:

> Majority (56%) of the population in the project area had not attained any formal education; 9.5% had lower primary education while 24% had upper primary. On the other hand, only 7.7% and 2.9% had completed secondary and tertiary level of education respectively (Infoscope 2013:16).

Once the CGs are established then the volunteers promote health-seeking behaviours to their peers, educate them on key health and nutrition messages, coordinate a referral and "alert and notify of early warnings for suspected outbreaks" (Medair 2014a:11). Since *volunteering is not known* in the culture, the project staff members had to make extra efforts to explain the tasks and the role of volunteers:

> It was noted that majority of CG promoters and volunteers don't understand the scope and roles of Care group and only a few were actively involved in health promotion, Care group officer was tasked with organizing in-depth meetings with all Care Groups and clearly articulating their roles and scope of duty (Medair 2015d:5).

Although the volunteers are key (Medair 2012:5) their workload should be appropriate. Especially in the context of Somalia the burden of women is high. Searching for food is a main activity for them, taking them away from home.

> This activity takes them away from the home and makes it excessively difficult to care for the children, and themselves. As consequence, women and children (both boys and girls equally) are at a greater risk for disease and malnutrition (Medair 2014a:14).

Additional commitment as a CG volunteer stretched the women's capacity and this has to be taken into consideration, as the documents confirm the interview statements.

Intervening conditions

Working with volunteers is part of the action strategies as seen previously; however, their *commitment* is an intervening condition for applying the CG model and formed the essence in the selective coding process. The recurring question about incentives for the volunteers was also found in the documents (Medair 2012:15). The importance, therefore, of motivating promoters and volunteers was confirmed by passages such as the following.

> The commitment, enthusiasm and increased knowledge of promoters and volunteers have resulted in the presence of strong community based role models (Medair 2012:16).

At the same time, the implementing organisation should be aware of the daily challenges of the CG volunteers.

Having role models in the community led to changed behaviour, although it was found in Knowledge, Practice and Coverage (KPC) surveys and evaluations that *traditional beliefs* could hinder the adaption of new health and nutrition related behaviour. One example from Somalia shows that although the women had the knowledge it did not translate into practice:

> It is noted that the Quran recommends breastfeeding for 2 years and this could have partly contributed to the high knowledge of the duration of breastfeeding. This would imply that factors other than knowledge influenced this practice since knowledge did not translate into practice (Medair 2015e:27).

The statements below highlight two of the traditional opinions about breastfeeding, but the compared figures of 2015 and 2016 in the second citation show already a change in convictions.

> […] early initiation of breastfeeding is not practiced by a considerable proportion of mothers under the belief that there is no milk production in the first three days after delivery and that "the first milk makes the child sick." (Medair 2014a:23).

> Maternal attitude on exclusive breast-feeding: Percentage of mothers of infants 0-5 months old who believe that a baby can survive on breast-milk alone, without even water: 37.9 (KPC 2015) to 54.0% (KPC 2016) (Medair 2016f:x).

Concerning health-seeking behaviour, Medair experienced that the communities have a "negative attitude towards health providers and clinics, which undermine public health" (Medair 2017a:10). Underlying traditional beliefs and cultural factors of that "negative attitude" might be sensitive, for example, it might be related to the role of traditional healers in the communities. Talking about deeply rooted traditional convictions requires an environment of mutual trust. The character of the relationship between CG volunteers and the neighbour women *is* such an environment of mutual trust and is, therefore, considered a "strong factor to overcome traditional beliefs" (Medair 2014a:23). This peer-to-peer support is even more influential with culturally adapted and customised messages, but the latter requires knowledge of the local culture and of potential barriers (intervening condition).

> The development of key messages must take into account community barriers and facilitators to ensure the messages are as adapted to the local context as possible (Medair 2012:18).

Consequences

The surprising results of the CG pilot project in Somalia led to *further implementation* in other programs of Medair.

> Considering the project has been implemented for only one year the results are notable. Community members at all levels are perceiving changes in child feeding, care and health (Medair 2012:19).

The community leaders in general were aware of the impact the CGs had, although there was one exception:

> The leaders perceived there was an increase in the number of mothers who breastfed their children and that children were healthier as a result. The exception was in the Daamast site where the community leaders were unaware of CG activities or any changes that may have taken place as a result of the project (Medair 2012:12).

In particular, the topics of breast-feeding, delivery with a skilled birth attendant, and hand-washing practices achieved *positive results*, as the different evaluations and surveys revealed. For example:

> Exclusive breastfeeding (EBF) for the first 6 months of life: Percentage of infants aged 0-5 months exclusively breastfed during the last 24 hours: 8.4 (KPC 2015) to 33.3% (KPC 2016) (Medair 2016f:x).

> The survey established significant improvements between the baseline indicators versus when the evaluation was undertaken particularly in areas such as deliveries assisted by skilled birth attendants which increased by close to a fifth from the original figure (56.6% to 72.9%) […] (Medair 2014c:vii).

Although the surveys, evaluations, and reports mainly focused on quantitative results Focus Group Discussions (FDG) were also conducted, which confirmed the substantial efforts of the CG volunteers.

> The findings from the qualitative data corroborates those from the quantitative data. There was consistency and agreement in the findings of the FGDs, both from the community members and the health workers that the coverage of the key indicators […] of health and nutrition had improved (Medair 2016f:33).

The selective coding process of the interview data lead to “empowerment” as the essence of the consequences of applying the CG model. The participants of the FGD expressed that they obtained knowledge about health and nutrition which is considered empowerment (see 2.3.2 Empowerment). Likewise, the CG volunteers were empowered and gained respect and status within the community through their commitment.

> Volunteers felt appreciated as they received recognition from the community for their role in promoting health in mothers and children. The sense of value from being entrusted with responsibility and their ability to develop personally has motivated them […] (Medair 2012:16).

The intent of the establishment of a CG network is to build up the communities’ resilience and their empowerment.

> Specifically, this integrated project promotes desired nutrition and health promotion and seeking behaviours intended to improve the community’s resilience to future public health emergencies (Medair 2014a:13).

5.2.2 Analysis of documents concerning the context of South Sudan

The available 16 documents about the context of South Sudan were related to two different project sites: Maban and Renk. In Maban, the program takes place in a refugee camp, whereas in Renk host communities and IDP/returnees' settlements are the focus. Figure 5.6 gives an overview of the 103 codes related to the South Sudan documents.

Category	Code	No of Codings
Operation of CG	SDS	0
	Organisation of CG & Numbers	1
	Training	0
	Formal & informal analysis	7
	Participation (Start)	0
	Coverage & information flow	6
	Meetings	2
	Teaching	2
	Data collection	0
	Promoters and their tasks	1
	Volunteers and their tasks	2
Partners	SDS	1
Sustainability of CG	SDS	2
Impact of CG	SDS	0
Topics covered in CG	SDS	8
Program activities beside CG	SDS	6
Context	SDS	0
	Political context	4
	Project context	18
	Cultural context	2
Challenges of using CG	SDS	0
	Culture	0
	CG Criteria	3
	Consequences of relief setting	8
	no payment (volunteering)	1
Involvement of the community at the beginning	SDS	3
Key aspects	SDS	2
Success	SDS	7
Backing through staff	SDS	1
Output of CG	SDS	10
Target group/Volunteers	SDS	2
Reason for working with CG	SDS	0
Recommendations	concerning NGO's attitude	2
Recommendations	concerning CG criteria	0
Recommendations	concerning the context	0
Recommendations	concerning volunteers & staff	2

FIGURE 5.6: RESULTS OPEN CODING OF DOCUMENTS (SDS)

As in the Somalia documents, the clusters "Output of CG" and "Operation of CG" were just as significant in South Sudan documents. In addition, South Sudan documents also contained an accumulation of codes in the categories "Project context" and "Success". In examining the individual codes within the categories, the researcher discovered that "Project context" and "Reason for working with CGs" do not contrast strongly. For example, the two statements below were assigned to the category "Project context".

> Out of the births which took place in a house, only 24 percent were delivered with the assistance of skilled birth attendants (Midwife/Nurse) (Medair 2014d:15).

> […] increased prevalence of some diseases such as diarrhoea, inadequate nutrition program coverage and decreased access to well-functioning health services for the host community due to a break in funding (Medair 2016e:2).

Since the low percentage of deliveries with the assistance of a skilled birth attendant is considered as a contributing factor to the mortality of pregnant women, the above-mentioned statement could just as well be coded with "Reason for working with CGs". Likewise, the factors listed in the second passage could either be considered to be assigned to the category "Project context" or to the category "Reason for working with CGs".

Applying the CG model in a relief setting

Successes, benefits and challenges of applying the CG model in South Sudan do not differ notably compared to the interviews; however, an additional finding was the good reputation Medair has in Maban where the organisation runs its program in the refugee camp Yusuf Batil. People left higher salaried employments with international NGOs in order to work with Medair due to the spirit and sense of community the Maban team stands for (Medair 2016c:23). Committed and motivated staff members are also key for the application of the CG model.

The challenges in the programming in Renk are different than in Maban. The population in Renk is not homogenous as in Maban, and Medair works among IDP/returnees as well as host communities. The SMART (Standardised Monitoring and Assessment of Relief and Transitions) and KPC survey 2014 found the camp population in better nutrition status than the host population (Medair 2014b:xlv). This could cause tensions and influence the CGs in some cases. Another aspect of Medair's engagement in Renk is handling the following contradictory situation: Medair increased its services and its performance but decreasing trends in health and hygiene behaviours were identified.

> In general, there has been marked progress in terms of general multi-sectoral indicators' performance in Renk County over the last one year reached by Medair services. However, this survey reports on various decreasing trends in health and hygiene behaviours […] (Medair 2016d:24).

Causal conditions

The above-mentioned situation of increased performance in Medair services but decreasing health and hygiene behaviours requires a *long-term perspective*. The development of the CG network is not quickly achieved, but it does finally influence health and hygiene behaviour.

Solid planning and having a thought through concept was defined as the essence of causal conditions. Selecting and placing Medair staff members is part of the concept. In the case of Maban it was even more important to consider cultural aspects when hiring employees. The environment was culturally sensitive. As the statement below illustrates, having a male CG volunteer would not be culturally appropriate in Maban when it comes to certain topics such as breastfeeding or safe delivery.

> For certain positions, such as midwife or Care Group Volunteer, Medair only employed female staff to promote access to culturally appropriate care (Medair 2016c:22).

Context

Sudanese refugees began to settle in Maban in late 2011 and until today the majority are living in the camp, as the pre-interview questionnaire states. The population is, therefore, settled and the people's movement is not high. Medair works among the refugees in Maban for seeking reduction in their mortality and morbidity through health and nutrition services as well as water treatment and distribution (Medair 2016c:7). Providing for the refugee population created tensions:

> Refugees in Maban obtain free food, education, healthcare, water, and other services to which they simply do not have access in Blue Nile, Sudan—even during peacetime. The disparity in services provided to refugees and host communities has created tensions and incentivizes refugees to stay in Maban (Medair 2016c:6).

In Renk, mass displacement was experienced in August 2016 due to insecurity and movement to Sudan continued (Medair 2016d:24).

> The climatic conditions combined with the economic deterioration and on-going conflict situation for more than 2 years has decreased Renk County's food security resulting in many people fleeing the country for Sudan and refugee camps to seek food aid (Medair 2016e:9).

The target group in Renk were the *IDP/returnee population as well as the host communities* who faced different challenges in terms of livelihoods and social factors (Medair 2015g:6). The CGs were initiated in 2015 for the two sections of Renk's population (Medair 2016e:10). Health and nutrition services were consistently accessed by IDP's and host community members and WASH services mainly by the returnees (Medair 2016d:4).

Intervening conditions

Since Maban had a model in place that functioned with paid health promoters, the transition to CGs had to be carried out carefully, because many hygiene promoters had lost their jobs (Medair 2016c:20). The *involvement of the community leaders* was, therefore, an important intervening condition for applying the CG model in this specific context.

> Especially involving village elders and community leaders and inform them about the survey results and specific concerns may help to find solutions together with the community. Village leaders and elderly have a huge impact on their communities […] (Medair 2016d:46).

Insecurity and food scarcity had a strong impact on the CG volunteers' commitment, as already stated in the interviews. As shown in the pre-interview questionnaire, people's living conditions remain an impediment (for example: in Maban the food rations were reduced; the women in Renk could not generate sufficient income to feed their children) as a result of a protracted crisis.

Action and interactional strategies

The original design of the CG model with its aspects remains the action strategy for applying the CG model also in South Sudan. The documents did not contradict the findings of the interviews. Explicitly confirmed were the aspects described in the following:

Providing *training* for the promoters as well as for the volunteers was already mentioned in the interviews as a recommendation for other implementing organisations. An evaluation gave information about Medair's "refresher training of trainers" (Medair 2016d:47) for promoters and CG volunteers. It was also

shown that training and capacity building is not easily achieved and external inputs may need to continue.

> Although Medair staff have exerted extensive efforts to build local capacity and transfer skills to refugees and local staff, the reality is that refugees in Batil camp and throughout Maban remain heavily dependent on external inputs […] (Medair 2016c:23).

To reach the target group with health and nutrition messages, an important action strategy is to *customise the content* to the respective culture in order to achieve changed behaviour (Medair 2016d:46). Barrier analysis could support the adaption of the specific message and its clear and effective communication (Medair 2016e:3). Part of an effective communication is practising the knowledge which is highly recommended in the internal evaluation of the CGs in Maban:

> When working with refugees, hygiene promoters and Care Group leaders should place greater emphasis on practicing the knowledge transmitted. They should clearly explain the importance of proper health and hygiene practices and actually do the practices with the refugees whenever possible (Maban 2016c:19).

Consequences

A consequence of applying the CG model was its *wide coverage*: 454 registered CG volunteers and 5,491 neighbour women in Maban by May 2017; in Renk there were 908 CG volunteers and 10,086 neighbour women registered as of May 2017 (according to the pre-interview questionnaire South Sudan). All these women receive knowledge and are being empowered in context. They could be quickly reached in a case of disease outbreak due to the strong network as the following example shows:

> The Care Group model has enabled Medair to quickly and effectively convey key health and hygiene messages to mothers with children under the age of five. For example, Medair leveraged the Care Group network to communicate to women the need to seek early treatment for malaria during the 2016 outbreak, which peaked at 3,366 cases in one week during July. By the last week of August, the number of cases had decreased to 1,491 cases, which Medair health staff attribute to the health messaging done vis-à-vis the Care Groups, the general insecticide spraying of water pools by the Mentor Initiative, as well as insecticide treated net distributions (Medair 2016c:13).

In the refugee camp in Maban, the number of mothers of under-fives who are members of a CG increased from around 10% in 2014 and 2015, to 79,7% in 2016 (Medair 2016c:11). Also in Renk the CG coverage augmented (Medair

2016d:24); however, a “reduction in key hygiene behaviours within the population” (Medair 2016d:35) was noted. In general, the coverage in Renk is higher for the host communities than the IDP/returnee settlements (Medair 2016d:44).

Among others, improved performance of IYCF practices (Medair 2016d:46) and “positive household and personal hygiene habits” (Medair 2016c:21) were directly attributed to the implementation of the CG model.

> The Care Group model played a crucial role in disseminating malaria prevention messages during the 2016 surge in malaria cases (Medair 2016c:5).

“The Care Group model is a tremendous asset […]” (Medair 2016c:5) was, therefore, one of the summaries.

5.3 Conclusion

This chapter presented the process and the results of the data analysis. Nine transcribed interviews with active or former Medair staff members as well as 25 documents with different contents (for example: donor funding proposals and reports, evaluations, surveys) were analysed according to the Grounded Theory, using the software MAXQDA12. Following the same analysis scheme, the data from the documents was used for the triangulation of the interview data. The data gained from the documents confirmed the interview data and no significant contradictions were found.

The next chapter presents the research report.

CHAPTER SIX: RESEARCH REPORT

This chapter summarises the findings of the available study in relation to the research objectives. Memos written during the interview and the document analysis process are important for compiling the research report. The discussion and reflection of the findings are done in the light of the literature review and finally lead to a transfer of the theory into the field of practice. The chapter closes with recommendations for further research. Due to the nature of the first three objectives (see 6.2.1; 6.2.2; 6.2.3), no explicit recommendations were formulated for those. Their purpose was to lead the researcher in gaining a solid basis of knowledge and understanding of the CG model and its broader context. The recommendations for the field of action were developed out of the results of objective 4 (see 6.2.4) and will be presented later in this chapter under objective 5 (see 6.2.5); however, as a first section, the research's methodology shall be reflected upon.

6.1 Reflection on the research methodology

The application of the CG model in Somalia and South Sudan was analysed on the basis of empirical data collected by interviewing nine experts and complemented by the examination of 25 different Medair documents. A review of relevant literature was conducted to put the CG model in a framework, and to study the context of Somalia and South Sudan. A general conclusion can be drawn that the research design and the method were appropriate, since the research objective and its secondary objectives were reached.

The interviews and the documents provided abundant data, which urged the researcher to remain focused on the research objectives and the frame of the study even though interesting side tracks opened from time to time. Also, the existing body of literature was immense and it had to be decided regularly which data corresponded with the scope of this research. It became evident why a clear and focused research question or objective must be defined before starting a study: the researcher was guided through the whole research process by the focal points formulated at the beginning.

Conducting the literature review first enabled the researcher to gain broad knowledge, for example, about ABCD, LRRD, the study's background and Medair's working context (Somalia and South Sudan). The empirical part followed, including the field study, and then, finally, composing the theory with the findings from the study revealed broad insights to the researcher. The structure of the study proved to be fruitful and taught the researcher to take one step of the research after the other.
Conducting all the expert interviews via Skype was ultimately more demanding than anticipated. Due to technical challenges and unstable internet connections, the foreseen time-frame was exceeded. Finally, one of the interviews even had to be accepted in written form. After transcribing and starting the first open coding cycle, the researcher decided to interview Medair's Senior Health and Nutrition Advisor as well. This brought further delay on the research schedule, but the inclusion of her perspective was worthwhile.

Conducting Focus Group Discussions (FDG) was considered but because of the researcher's personal situation, which made travelling difficult, the workload of Medair staff, as well as the security situation of Somalia and South Sudan, the decision was made against it. Triangulation of the interview data was possible due to the quality of the available documents. No significant contradictions were found. The interview data was validated and complemented through the document analysis as summarised in the following sections.

6.2 Summary of key findings

The summary of the research process shall be presented here. Not all findings will be conveyed again. The summary concentrates on the key findings in relation to the initial research objective: *Analysis of the application of the Care Group Model in a relief context in light of its original design and methodology for a development setting.* The secondary objectives contributed to the analysis of the application of the CG model and shed light on it from different perspectives. The secondary objectives also serve as a structure to present the key findings in the following:

6.2.1 Theoretical framework to place the CG model into context

Objective 1: To study the asset-based community development, on the basis of selected literature, as the theoretical framework in order to place the Care Group Model into context.

This objective contributed to the primary research objective in terms of the general development context. ABCD as the theoretical framework challenged the researcher to analyse the CG model in a different light than the practical aspect. To start off with a résumé: the CG model is not in complete conformity with ABCD; however, it does capture several aspects of that community development approach. Reasons for this résumé shall be given next.

Basic conviction of ABCD is that every community, even the most challenged ones, has assets (resources and strengths) (Kretzmann, McKnight, Dobrowolski & Puntenney 2005:31). The analysis of the application of the CG model in Somalia and South Sudan has proven this notion right. Communities of the case study face severe challenges related to protracted conflict. The civil war, in addition to a severe drought and the lack of supply of basic products in Somalia (Shay 2014:15) left more than a million refugees and five million people starving within the country (Shay 2014:16). In South Sudan, 4.9 million people are food insecure across the country (ACAPS 2017a:1) and 6.1 million people are in need of humanitarian assistance (OCHA 2015a:2). It seems unlikely that the affected population could contribute to the improvement of the community's health under these living conditions marked by food scarcity and insecurity. Nevertheless, the CG model builds on assets that are to be found in every community, and the method was implemented in refugee communities, host communities and IDP communities. Broad networks as well as strong relationships among the community members had developed, and women became role models for their neighbours in spite the difficult living conditions. According to Philipps and Pittman (2009:6), people and the connections among them are a community's main characteristic and network building is considered crucial in ABCD (Kretzmann & McKnight 1993:346). Particularly in a relief setting, community is all that is left (Interview Susan).

The aim of development interventions to improve people's living conditions should culminate in strengthening the individual's self-responsibility and opportunities for participation, including an active role in society (Sangmeister & Schoenstedt 2009:142). In one of the interviews it was stated that the participation aspects might not be easily put into practice when applying the CG model (Interview Laura). This is not unexpected since the CG model is a method with clearly defined criteria and, therefore, the community cannot participate, for example, in designing the model. Community mobilisation marks the commencement of the implementation. Community and leader decision-making (De Beer & Swanepoel 2011:37) is respected in that it is their choice whether the CG model finally takes place in their area or not. Since the CG volunteers experience their ability to make a difference, the CG model promotes a "transformative form of participation" (White 1996:7).

The second core element of ABCD depicted in the literature review was "empowerment", that is: to provide "people with the resources, opportunities, vocabulary, knowledge and skills to increase their capacity to determine their own future, and to participate in and affect the life of their community" (Ife 2013:277). The CG volunteers are being empowered through knowledge gained, and as role models of changed health and nutrition behaviour they affect "the life of their community". It was confirmed in the interviews in various examples that the CG volunteers gained respect within the community and their status changed for the better. Moreover, empowerment strengthens resilience, which was also stated in the interviews ("There is also an unqualifiable resilience component […]" (Interview Len)).

A justification for Medair's application of the CG model in a relief context was found in the explanation of FAO (2016:8) about the long-lasting negative impacts of people's displacement and food scarcity due to armed conflicts that both Somalia and South Sudan face. FAO (2016:2) names the malnourishment of its children as the multi-generational unfavorable consequence on a society. If children have no access to nutritious food during a certain phase of their development then they are at great risk for developing mental and physi-

cal handicaps. Medair, therefore, put the emphasis on Infant and Young Child Feeding when it comes to topics covered by the CGs.

> The practice of exclusive breastfeeding still needs special attention in the messages communicated to the community, as exclusive breastfeeding is closely associated with immense health and nutrition benefits to the child (Medair 2016f:28).

Although Medair is a humanitarian organisation it links life-saving emergency aid and medium-term interventions for building the beneficiaries' resilience to future crises (Medair 2014a:13). Working closely with local partner organisations, as Medair does in Somalia (Medair 2014a:25), fosters sustainability even though the program is taking place in an unstable context. This is the objective of LRRD: to combine the strengths of humanitarian action and development cooperation.

6.2.2 Origin, focus and method of the CG model

Objective 2: To explain the origin, focus and method of the Care Group Model.

This research objective covered the aspect of the original design and concept of the CG model. The model was invented as a community-based health care approach in a development setting in Mozambique (World Relief 2004:5). The aim was to reach a large population with health messages in a cost-efficient and sustainable way. Although the interventions and the context may differ, the core elements of the CG model (volunteer effort, peer support and community mobilisation) remain the same (World Relief 2004:6). The so-called CG criteria define whether the implementing organisation is allowed to call the program CG or if another term should be used, such as cascade groups. The CG criteria contain 13 required and four suggested principles. These principles will be addressed later in focus when summarising the secondary objective 4) and reflecting upon the key elements of the CG model.

Contrary to the original intention, Medair applies the CG model in a humanitarian setting. The Medair aim is to reduce morbidity and mortality of pregnant or lactating women and children under five years by spreading health prevention and nutrition messages effectively. The target group is part of either refugee communities, IDP/returnee communities or host communities. The meth-

odological aspects of peer-to-peer learning and volunteering also remain when applying the CG model in the context of the case study.

6.2.3 Contrast the application of the CG model in context of Somalia and South Sudan

> Objective 3: To contrast the application of the Care Group Model to the context of Somalia and South Sudan, regarding the challenges and successes.

This objective covered the aspect of practical application in the two countries, Somalia and South Sudan. Since the context in these two countries of Medair's operation is comparable and the frame of the CG model is clearly defined (criteria), the findings of challenges and successes of the application of the CG model do not differ significantly.

The vast network developed through the application of the CG model is considered one of the successes in both countries. Due to many connected households the information flow is fast and messages can be spread in a timely manner. This is an immense benefit in case of a disease outbreak, for example. The networks in Somalia and South Sudan serve as a feedback mechanism for Medair (see Interview Len), either in terms of security or in terms of knowing what is happening in the community (for example: sudden outbreak of acute diarrhoea), which allows Medair to search for root causes of a problem (for example: checking on the water sources) and find appropriate solutions. Establishing the network seems to be a challenge (for example: see Interview Laura), and its size frightened some local authorities (see Interview Susan) but once implemented it is a valuable resource.

A variety of outcomes on different levels could also be considered as a major success of the application of the CG model in Somalia and South Sudan. Measurable changed behaviour of hand-washing practices or IYCF were found in the documents as well as mentioned by the interviewed experts. Another outcome is the empowerment of women and their raised status and respect within the community. Further, the sustainability of the CGs and the developed relationships among community members had improved with the ap-

plication of the CG model and became a strong asset of the community which could also be seen as peace-building. Due to clan issues, there were no relations among some community members who belong to different clans. Only through the CGs did social interaction start (see Interview Laura; Ajib; Daniel).

A considerable challenge that was found is the unfamiliarity of the concept of volunteering as such (see Interview Ajib; Jacob). People care for their family and extended family, but committing oneself for no salary to support the community needed to be explained first in both countries. Volunteers often expected financial or material incentives and it led to some tensions when implementing the CG model (see Interview Jacob; Susan; Evan). In addition, people in the refugee camps or IDP/returnee settlements struggle with their daily life since they have lost almost everything. The priorities might not be on volunteering at all or might shift depending on the season (see Interview Daniel). Commitment, elaborated as the essence of intervening conditions (selective coding), is threatened by the difficulties people face in both contexts. The latter leads to considerable movement of the population which is a challenge for implementing the CG model. As interviewees explained, the population needs to be at least semi-static to make the method of CGs work (see interview Laura; Emma).

In Renk, South Sudan, Medair faces a unique challenge compared with the programs in Somalia or South Sudan. Although the coverage of the CGs increased and changes in people's behaviour were measured, the following survey reported a rather significant decrease of some practices (2016d:35). Reason for that development had not been found yet.

6.2.4 Key elements of the CG model applicable to the context of a protracted crisis

> Objective 4: To examine on the basis of the case study which key elements of the Care Group Model can be applied to the context of a protracted crisis.

This objective covered the aspect of the protracted crisis and the comparison of the original design with the actual application of the CG model in Medair's

programs in Somalia (IDP settlements and host communities) and South Sudan (refugee camp, IDP/returnee settlements, and host communities).

The contexts of Somalia and South Sudan are comparable both countries are marked by a chronic conflict situation or protracted crisis. This affects the socio-economic conditions as well as the livelihoods of a significant portion of the population (Jones 2004:15). The similarities of the contexts made it possible to combine the findings from Somalia and South Sudan and then compare them with the CG criteria (13 required and 4 suggested criteria constitute the original design of the CG model). As stated above, it was found that the CG criteria were transferred into the context of chronic conflicts. There were challenges in regard to the implementation of the CG criteria, but Medair was able to follow the original design of the CG model. An exposé about the individual criteria shall be given in the following:

Selection of CG volunteers

CG volunteers should be chosen by their neighbour women or by the local authorities. Medair's experiences are in line with this CG criterion and volunteers had been selected by their neighbours or by the community leaders. Also, the involvement of community elders and other local authorities had been proven vital. Their impact on the community is strong and their support of raising awareness and spreading health and nutrition messages is crucial for behaviour change targets. In case of concerns, survey results could be shared with the community leadership and appropriate solutions could be found together (Medair 2016d:46).

Limited workload of CG volunteers

Several interview statements (see Interview Len; Fatima; Evan) agreed upon the key role of CG volunteers for the success of the method. Analysis of the context and the volunteers' living conditions revealed, however, that these women were already stretched by the struggles of their daily lives. Their workload should, therefore, not exceed 15 households, as defined in the CG criteria. In Maban, a CG volunteer was responsible for 12 neighbor-women, in Renk for 11, and in Somalia for 15 in urban areas, and 12 in rural areas.

Some of the interviewees emphasised the need to take good care of the volunteers (see Interview Fatima), meaning constantly motivating and encouraging them.

Limited CG's size and meeting frequency

For the sake of participatory learning, the CG's size is limited to 16 members. In Somalia, Medair had a group size of 10 CG volunteers, in Maban 10 to 12, and in Renk ten. The CG met biweekly (required: once a month) that had been monitored by attendance sheets.

The CG volunteers again met biweekly with their neighbour households to share the learned message. The meetings were monitored through unannounced visits by the promoter. This applies for both Somalia and South Sudan.

Coverage

Due to population movement, the criterion of covering at least 80% of the targeted households monthly is, in the case of Medair's working context, one of the most threatened ones (see interview Laura). In Somalia, the coverage was not mentioned explicitly, although people move there also in that context. In South Sudan, the population is more stable in the refugee camp in Maban, whereas in Renk people move due to insecurity or food scarcity (see interview Daniel; Len). Medair is challenged to re-do the mapping more often in Renk and the CGs are affected by changes (see interview Laura). The criterion was met in Maban and was increased in Renk (see interview Daniel; Emma).

Vital events data collection

The CGs in all Medair programs collected data about vital events (for example: pregnancies, births, deaths) in the respective communities as required in the CG criteria. The challenge that had to be met was the illiteracy of the majority of the volunteers. In Maban, the CG volunteers first had to learn the numbers which worked well after a while. They were able to tally sheets correctly although they could not read and write (see Interview Laura). In other programs, the CG volunteers and the promoter met bi-weekly and the volun-

teers reported to the promoter who filled the lists instead. A rather big body of data was collected in that way (see Interview Len). This steady stream of data allowed Medair to adapt its interventions when necessary (Medair 2015d:4).

Creation of behaviour change/topics covered

It is required that the majority of what is promoted through the CG creates behaviour change directed towards the reduction of child and maternal mortality, morbidity and malnutrition. The curriculum and messages should be compiled accordingly. Medair used the CG model as it was designed and spread health and nutrition messages in order to reduce morbidity and mortality of pregnant or lactating women and mothers of children under five. This section of the population is already vulnerable in a development setting, but even more so in a relief context (see interview Susan). Related to the conflict situation, women often face sexual and gender based violence (SGBV) and in some CGs topics these had been covered on a very basic level (see interview Evan; Fatima). Psychosocial support had also been considered and was integrated in some CG meetings. Since the CG provides a safe place for women it offered the opportunity to talk about topics related to their experiences by keeping the overall goal of creating behaviour change directed towards reduction of child and maternal mortality, morbidity, and malnutrition in mind.

Teaching method and teaching sessions

Medair placed emphasis on consistent messaging and use of visual tools, as this criterion requires. The booklets and pictures that the CG volunteers had been using for health promotion on household levels were also displayed on posters in health facilities (see interview Susan). Some CGs developed songs and dances for taking the messages to their neighbours (see interview Laura).

The criteria of participatory methods were combined with the criterion of visual tools as well as the instructional time from promoters to CG volunteers, since they complement each other. CG volunteers received training once or twice a month. The training sessions were held by the promoters and adult teaching methods were used. The messages were not just taught formally, but the CG volunteers had to discuss, make conclusions and put the messages into prac-

tice (see Interview Jacob). Depending on the content of the lesson, the instructional time varied. Sometimes the promoter provided cooking sessions or other practical demonstrations related to the topic. In that case, the teaching took longer than sessions without practical training. An internal report highly recommended placing more emphasis on practicing the knowledge transmitted (Medair 2016c:19). Average duration of a teaching session was given as one and a half hours.

Supervision

As provided by the criteria, supervision of promoters and supervision of CG volunteers occurs, but the frequency varies depending on the context. Checklists had been used to give and receive feedback and support (see Interview Ajib; Fatima). These sessions allowed the promoter to motivate and encourage the volunteers as stated in the interviews as key (see interview Len; Fatima).

Geographical proximity

To avoid time-consuming travelling of CG volunteers, the CG criteria require a maximum distance of a 45-minute walk to the visited households. In Somalia, the CG volunteers in urban areas lived within 50 metres of their neighbours, in rural areas the walking distance was approximately 500 metres (see pre-interview questionnaire). In Maban and in Renk women walked five to ten minutes to get to their neighbours' places.

The geographical proximity is an advantage in an unstable context, since no travelling is necessary which minimises insecurity (Medair 2014a:24).

Respecting the culture and empowering women

The project/program culture should convey respect for the population and the CG volunteers and foster their empowerment. Respecting the population also implies customising the behaviour change messages to the local context. It had proven important to understand the culture and the experiences of the target group for formulating credible lessons (see interviews Laura; Evan; Jacob). A barrier analysis helped to analyse the thinking of the people in the re-

spective cultures about certain topics and related traditional beliefs (Medair 2012:7). The peer-to-peer model supports the idea of customising the messages as much as possible, since the promoters and the CG volunteers belong to the same community and have the same cultural background as their peers, the neighbour women. They know the best starting point for sharing the behaviour change messages (see interview Fatima; Medair 2014a:24) and because they were a role model for the community, behaviour eventually changed (Medair 2012:16).

Empowerment is happening in the sense that women increase their knowledge and especially the CG volunteers gain respect because of their commitment and their knowledge of what they are sharing. In one interview it was stated that the women only now felt part of the community (see interview Ajib).

The following 4 criteria are not required, but suggested principles.

Formative research

KPC surveys were an important basis for defining the CG curriculum in Somalia and in South Sudan (Medair 2014d:4). As it was found that pregnant or lactating women and children under five are the most vulnerable (see interview Susan), the surveys delivered further information for specific topics to be covered by the CGs. For example, in all of Medair's CG programs emphasis was placed on exclusive breastfeeding as a "simple" method for supporting the child's healthy development and growth, even in emergency circumstances. KPC surveys provided the necessary information.

Promoter–CG ratio

It is recommended that the promoter-CG ratio should be no more than 1:9. In Somalia, the ratio is one promoter to six to eight CGs (see pre-interview questionnaire). In South Sudan, a promoter is responsible for five to nine CGs (see pre-interview questionnaire).

Annual measurement of results

Medair conducts, at least annually, surveys of their programs (Medair 2014d:4). CGs are an integral part of Medair's multisector programming and, therefore, the results of the CGs were included in these surveys. In some cases an increased indicator coincided with the start of CGs.

Background of promoters and CG volunteers

Significant social and educational differences between promoters and CG volunteers were not mentioned by Somali staff or by South Sudanese staff. It was explained that a condition for becoming a promoter is the ability to read and write which is not a requirement for CG volunteers. The literacy level was the most notable difference mentioned.

6.2.5 Debate of results and recommendations for the field of action

> Objective 5: To debate the results of the analysis of the case study and to formulate general recommendations for applying the Care Group Model to the context of a protracted crisis.

This objective covered the aspect of the field work and resulted in recommendations for the field of action.

As the research revealed, the CG model is a multifaceted method, especially in the context of a protracted crisis: a tool for behaviour change (its sole initial primary intention); time- and cost-efficient spread of messages; support of peace-building; strengthening of relationships and voluntarism as assets of a community; providing a safe space for women (psycho-social support); enabling capacity building and empowerment; early warning system for disease outbreaks or outbreaks of armed conflict, and so on. Some of these and other aspects shall be highlighted hereafter, resulting in recommendations for the field of action.

The analysed application of the CG model in Somalia and South Sudan showed that it is an appropriate tool for behaviour change in a protracted crisis context; however, some preconditions are required. For example, the population needs to be at least semi-static and not in an acute emergency situation, and thus no longer in survival mode (see Interview Emma; Laura; Len;

Susan). Due to food scarcity and insecurity in Somalia and South Sudan, total prevention of people's movement is not realistic but in the rather stable communities within the refugee camp in Maban and in some IDP and host communities, Medair could implement the CG model and achieve appealing results. In Renk, where waves of insecurity and higher seasonal movement was attributed to the context, the application of CGs faced challenges, for example: non-attendance of CG meetings; Medair needed to redo the mapping more often thereby decreasing trends in health and hygiene behaviours (Medair 2016d:24); and so on.

► It is recommended to restrict the introduction of the CG model in a relief context to communities with at least semi-static population. Some of the underlying principles (for example: general behaviour change principles such as: if volunteers are involved then the volunteer-household ratio needs to be low; teaching of planned lessons; keeping the meetings short; short distances, etc.) might be useful even in acute emergencies; however, the application would then not carry the name "CGs".

Medair's CGs benefited from an integral approach and a multisector program that was already in place in Somalia and in South Sudan. The activities were linked across the sectors (health, nutrition, WASH). This provided the foundation for timely reaction to incidents in communities (for example: when one CG reported an outbreak of acute diarrhoea, the WASH team was asked to check the water source and the water storage (see interview Laura)). Another benefit of multisector programming was the effectiveness in terms of time. Changed behaviour was reached in a relatively short period of time (Medair 2012:19). This is crucial in a relief setting since the programs are often not multi-year programs and the setup of the CG model was reckoned to take at least six months. The network needed time to develop (Medair 2016d:47) and people only began a full appreciation of the CG model when it had gone to full phase (see interview Evan).

The same also applied, to some extent, to Medair staff. The organisation, therefore, acquired positive experiences in having a staff member or a whole team who believed in the model and was dedicated to its implementation.

► The recommendation for applying the CG model in a relief setting is to integrate it into an established multisector programming and anticipate possible challenges through a solid planning of the implementation.

► The recommendation for implementing the CG model is to have a staff member or a team who is dedicated to set up the structure of the method (see interview Susan; Laura).

Customising the health and nutrition messages to the target group's culture is a crucial factor for changed behaviour (see interview Laura). Communication across cultures is demanding and requires sensitivity as well as a solid knowledge of the culture, traditional beliefs, religious aspects, language and so on (see interview Evan; Daniel; Jacob; Medair 2017a:10). The peer-to-peer concept of the CG model is responding to cultural specifications, possible language barriers, and in covering culturally sensitive topics (Medair 2014a:23). Also, the involvement of local leaders at the beginning and the community throughout the project increased the credibility of Medair (Medair 2016c:23; Medair 2016c:46) and fostered culturally appropriate decisions (see Interview Evan: If not recognised, clan structures could be a stumbling block for the project).

The context in a protracted crisis is usually a complex matter. The analysed documents expressed that in some cases tensions between the host communities and the refugee or IDP communities existed (Medair 2016c:7). "Host communities are less well served in Mogadishu…" was one of the statements (Medair 2013b:1). Close collaboration with a local NGO could be helpful in overcoming the disparity of access to services and reducing tensions between the different communities.

On the other hand, interviewees, including the pilot-interview participant, explained that the CG model fostered relationships and built the basis for overcoming prejudices between clans and communities (see interview, Ajib; Jacob: Daniel).

► It is recommended to get to know the prevailing culture and the context well or seek local advice in decision-making and in customising the messag-

es. Either way, acknowledging the local reality is crucial when applying the CG model in a protracted crisis.

► The recommendation concerning staff, promoter and CG volunteer selection is to involve the local authorities and the community. Awareness of ethnic dimensions is an important pre-condition for implementing the CG model especially in a chronic conflict context.

People's living conditions and circumstances related to the relief context or protracted crisis, as in Somalia and South Sudan, challenged the transfer of the gained knowledge into practice. For example, mothers were taught in the CG sessions to exclusively breastfeed their children; however, even though they understood the advantages and benefits, they themselves did not have access to sufficient food and therefore hesitated to put the knowledge into practice. Medair linked the affected women with WFP and their nutrition programs and kept teaching exclusive breastfeeding (see interview Evan).

Another interviewee mentioned the mental distress as a consequence of experiences related to the chronic conflict that affects the ability to put the messages learned into practice. Traumatised people are hardly capable of learning new behaviours and changing old habits (see interview Daniel; Laura).

► The recommendation is to be sensitive about the experiences people had due to the chronic conflict and to formulate realistic expectations of behavior change, given the circumstances they are living in.

Medair's CG pilot project in Somalia had proven the model as suitable for the context Medair is working in. The goals had been achieved that the NGO struggled with previously (see interview Emma). Even if the performance might not be perfect in all aspects, women gain knowledge and take it with them should they move, flee again or return home. Knowledge is mobile, and improved behaviour is a powerful transformative practice (see interview Laura). Five years after the pilot project was implemented, Medair is convinced about the usefulness of the CG model in a protracted crisis and the method became standard for Behaviour Change Communication in multi-year programming (see interview Emma). All the interviewed experts expressed

their appreciation for the CG model since they had personally experienced the field work and seen its impact.

► The recommendation is to steadily increase the experiences with the CG model as an NGO. It might be wise calling it, for example, “cascade groups” at the beginning and not “CGs” until after implementing criterion after criterion. Persistence might be required during the implementation for several reasons, for example: voluntarism might be unknown in the host culture; security issues may hinder meetings, food scarcity may force CG volunteers to set their priorities differently.

► The recommendation is to foster the commitment and conviction of the CG model of the implementing staff through, for example: supervision.

The first goal of the CG model is to communicate behaviour change messages to the target group of pregnant and lactating women and mothers of children under five; however, the interview data revealed that the empowerment of the participating women went beyond changed behaviour. Fostering the asset of strengthened and newly built relationships has already been mentioned. Furthermore, women were inspired due to the dynamic within the CG and used the CG structure for their own social benefit (for example: English lessons, see interview Laura). They did not want to leave the group, even though they did not receive any incentives (see interview Jacob). The CGs became a safe and reliable space for women to meet and support each other in the midst of the conflict. This is considered psychosocial support, even if the topic might not be explicitly taught.

► The recommendation is to foster the positive impact of the group’s dynamic even if it might not fit perfectly into the curriculum. Particularly in a chronic conflict situation, having a safe and reliable space for women is crucial for their wellbeing and contributes to their resilience.

A common statement was the challenge of expected incentives for the CG volunteers. As elaborated earlier, the concept of voluntarism is not known in certain cultures. This caused tensions between staff members and the CG volunteers, and discussion with community leaders had to be sought (see interview Ajib). Since volunteers are key to the success of CGs, their motivation

and encouragement had to be upheld, but in other than financial terms. Three aspects crystallised: firstly, the respect the volunteers gained through their commitment for the community from leaders and community members fostered their motivation (see interview Ajib; Medair 2012:16). Secondly, the results revealed by evaluations showed them their role in an improved community health situation (see interview Evan). Thirdly, regular supervision, training and support from promoters and Medair staff to CG volunteers was appreciated (see interview Fatima).

Mattessich (2009:55) states that sustaining developed social networks and the community's capacity requires on-going efforts and thus training and supervision are important factors for the sustainability of the CG model; however, although Medair built up local capacity and transferred skills to refugees and local staff, refugees throughout the Yusuf Batil camp "remain heavily dependent on external inputs" (Medair 2016c:23). Their capability remains limited due to the circumstances they are living in. Where applicable, Medair works closely with national NGOs to build their capacity and finally to hand over the program (see interview Evan).

Voluntarism as such is also an aspect of sustainability, since it is more likely that the activities will continue after the NGO has withdrawn if the volunteers are not paid (see interview Fatima; Emma).

► It is recommended that the volunteers' encouragement and support should be institutionalised.

► It is recommended to build the capacity of local staff as well as of local NGOs for the sake of sustainability and continuation of CGs after the implementing NGO as left. Where not applicable, it is recommended to develop other mechanisms that enable the CGs to continue after the withdrawal of the implementing NGO (for example: to develop village health committees; build links between the CGs and local health facilities).

6.3 Topics for further research

Following the previous section and because of the narrowed down research objective with focus on the application of the CG model in Medair's working context in Somalia and South Sudan, topics for further research arose.

► Due to a lack of resources and capacity, strong monitoring and evaluation of the CGs specific impact could not be conducted by Medair. It was suggested to carry out a Randomised Control Trial and compare the indicators of the Yusuf Batil Camp with other refugee camps.

► Moving population was mentioned as a challenge for the application of the CG model in a chronic conflict situation. Further research on how to reach a moving population with Behaviour Change Communication without betraying the CG criteria could be valuable.

► Context-specific further research could be conducted in collaboration with a complementary field of science (for example: psychology) of how to reach a traumatized population with basic messages related to psychosocial needs. An additional part to the CG curriculum could be developed, concerning basics of psychosocial wellbeing for people living in a chronic conflict situation.

► Since the CG model is based on voluntarism but certain cultures do not know about this concept, further research on awareness-raising and on how to motivate and mobilize a community for voluntary commitment would support the effective implementation of CGs.

► It was mentioned that Medair involved men in the CGs, since in many cultures men are the decision-makers. Further research would be advantageous on how to tie in the men and whether some adaptations of the CG model (curriculum; approach of a community; group structure etc.) would be necessary for involving the male decision-makers.

6.4 Conclusion

This chapter reflected upon the research methodology and summarised these research findings in relation to the primary research objective, complemented by the secondary research objectives. The latter provided the structure of the research report and the findings were summarised objective by objective. A main finding was that the CG model can, under certain conditions (for example: at least a semi-static population), be applied to a relief context. It might be more challenging in a relief setting than it is in a development context to put some of the criteria into practice (for example: the coverage might be irregular due to people's movement). Nevertheless, it is possible to implement the CG criteria and use the model as a tool for Behaviour Change Communication in

a relief context. The secondary objective 5 also included recommendations for the field of action, developed from the case study. The chapter concluded a list of topics for further research.

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ANNEXURES

Annexure A: Consent form for Interviews (example)

CONSENT FORM for INTERVIEWS

"Applying the Care Group Model in a Relief Context:
Case Studies in South Sudan and Somalia."

This study focuses on the application of community based interventions in relief work. The application of the Care Group Model within the work of Medair (a Swiss humanitarian NGO) in South Sudan and Somalia serves as an example for the case studies.

You have been asked to participate in this study, because you are either Medair staff member or former Medair staff member, experienced in working with Care Groups.

With my signature I confirm that,

- I agree to participate as an interviewee in this study.
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
- I understand that all data collected will be limited to this use.
- I understand that my anonymity will be preserved.
- I am aware that the interviews will be audio recorded and all records will be kept confidential.
- I understand that the data I will provide are not to be used to evaluate my performance as a relief worker in any way.
- I acknowledge that the contact information of the researcher have been made available to me along with a duplicate copy of this consent form.

.....

Participant's Name (Print)

....

Signature Date

Researcher: Damaris Peter; Student number: 58550186
Contact Details: Toesstalstrasse 256, CH-8405 Winterthur; Phone: +41 76 580 09 82; dama.peter@bluewin.ch

Annexure B: Pre-interview questionnaire

PROGRAM CONTEXT	1. Please describe briefly the setting where you are using CGs. Is it a refugee/IDPs camp, a community within the camp, a host community?
	2. Community Setting: Please describe briefly the general context of the community where you are using CGs (e.g. mainly female headed households; a mobile population due to insecurity or seasonal moving)?
	3. Camp setting: Please describe briefly the general context of the camp/ the community within the camp where you are using CGs (e.g. how long is the average stay of IDPs or refugees in the camp).
	4. What ethnic groups, religions and languages are present in the community/camp you are using CGs; how are the relationships between the different groups?
	5. What are the main income sources of the target group?
	6. What are the main challenges your target group faces for living?
FACTS & FIGURES ABOUT THE CGS IN YOUR PROGRAM CONTEXT	1. How close do people in the camp/community live? How long does a CG volunteer need to walk in average for visiting a household?
	2. For how many households is the CG volunteer responsible in average?
	3. How many members do the CGs have?
	4. How often does the CG meet?
	5. How do the CG monitor the attendance?
	6. How often are the individual households being visited?
	7. How are the meetings and the visits monitored?
	8. For how many CGs is one promoter responsible?
	9. How often does the promoter meet with the CG volunteers for one-to-one supervision?
	10. What information was collected by Medair about behaviours before starting CG (baseline)? What method did you use?
	11. How often do you ask about changes in the people's behaviour (monitoring)?

LINKING RELIEF REHABILITATION AND DEVELOPMENT	1. For how long is Medair going to run the program?
	2. Who is taking over after Medair withdraws? Is there already a partnership with a development organisation established?
	3. Does the funding partner request cooperation with development organisation? If yes, how should the cooperation look like?

Annexure C: Interview guide

TOPIC	KEY QUESTION	SUPPORTIVE QUESTION
Context	How did the CGs start and how have they developed so far?	Why have CGs been started in your context? How were the participants involved in the start of CGs? What was the biggest challenge the community was facing?
	What is your target group?	For example: women in reproductive age; mothers of children under 5…
	How does the relief situation affect these people?	
CG criteria	How does the CG Model operate in your program?	○ Who selected the participants? ○ Have the participants been invited to be part? ○ How did they get to know about CGs? ○ Do the CG volunteers collect data? How? →If yes, what kind of data and for what partner? →If no, what are the hindrances? ○ How do they teach? What visual tools do CG volunteers use? ○ How long are the teaching/training sessions for CG volunteers?
	Please characterize the CG participants briefly.	○ How diverse are the CG volunteer's backgrounds in terms of religion, ethnicity etc. in your context? ○ What is their education level?
	What topics do the CGs in your context cover?	
LRRD	What other activities are being carried out besides CGs in your program/project? How are they linked to the CGs? Is there a collaboration with other programs/projects? If yes, how?	For example: other WASH activities, health activities …

TOPIC	KEY QUESTION	SUPPORTIVE QUESTION
	What may happen to the CGs after Medair withdraws?	
Success and benefits of using CG in relief settings	What impact of the CGs do you see on your targeted group?	○ What can you say about social bonds? ○ What could you observe concerning psychoso-cial support? ○ How would you describe the changed behaviour?
	What success do you see concerning the implementation and the use of the CG model in your context (output)?	○ How effective are the CGs? ○ How is the coverage of your target group? ○ How is the spreading of messages? ○ What do you observe concerning the role of CG volunteers in their community (for exam-ple: a trusted channel of information)? ○ Do you see CGs as a system for monitoring, screening and referrals in your context? ○ What can you say about sustainability?
	What else do you consider as a benefit of the CGs in your specific context?	Do you see any other changes since beginning the CGs? Please describe them.
Challenges of using CG in relief settings	What challenges do you face using the CGs in your context?	
	How does the relief situation affect the CGs?	How does insecurity affect the CGs? How does the people's movement affect the CGs? How does mental dis-tress of the people affect the CGs? How does the lack of social structures affect the CGs?
	What would you do differently if you would implement CGs again? What lessons have you learnt?	

Recommen-dations	What recommendation would you give to other implementing organisations? Are there other aspects that are important to understand?	What do you consider as an important remark about using the CGs in your specific con-text?