

## **Report on the First Coordination of SO7 Stakeholders**

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September 21-23, 2004, MPlaza hotel, Accra

version of 29 October 2004

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# **First USAID/CA healthportfolio coordination meeting**

*September 21-23, 2004, MPlaza hote, Accra, Ghanal*

## **1. Purpose**

to lay a solid foundation for coherent, coordinated project implementation of the Health (SO7) Strategic Objective, [Health Status Improved], including:

- A shared vision of the accomplishments of five years of concerted action from all health portfolio stakeholders
- Clarity on expectations of the various partners (Ministry of Health/Ghana Health Service, USAID Health Team, Cooperating Agencies [CAs])

## **2. Objectives of the meeting**

- Build consensus on the common challenges
- Produce a consolidated work plan to provide all stakeholders with a coherent view of the Health portfolio
- Get commitments from each partner on how they will support the others
- Reach agreements on roles and responsibilities from each group regarding cross cutting issues and activities
- Reach agreements on what to do in case of breakdowns
- Establish specific next steps (e.g., continued work plan discussions; next coordination meeting; other)

## **3. Agreements and products of first coordination meeting**

### ***3.1. What actions do we need to take to ensure effective coordination?***

[In no particular order]

- Create a vision
- Have clear goals
- Agree on timelines
- Check what is changeable/negotiable (give and take)
- Recognize linkages and resources
- Define rules, procedures, roles
- Make coordination a legitimate task (in job descriptions, resources allocated)
- Share information
- Document agreements
- Hold people accountable to agreements made
- Communicate frequently (formally and informally)
- Set a climate that is conducive to coordination/be a good example

- Use people who have good coordination skills (interpersonal, negotiation, conflict management, big picture or detail oriented depending on task at hand, etc.)
- Avoid blaming
- Celebrate successes
- Recognize strengths and weaknesses of each other and allocate responsibilities with those in mind
- Work on the relationships

### **3.2. What are our concerns and doubts regarding the implementation of this ideal? (How to coordinate well)**

#### **\*Concerns about power differentials and trust**

Doubts about larger contractors working in coordination with smaller grantees or NGOs

Also large PVOs/contractors sharing information

Need respect and equity, regardless of size of project/organization

How much can I trust the donors and other partners' commitment?

#### **\*Concerns about having all the information**

Can I deal with all the complexities of documentation?

Do I know enough to commit to the coordination strategy?

These do not consider the role of the beneficiaries; the people who will receive the assistance

#### **\*General skepticism about putting this into practice**

Are these views real or rhetoric?

The model depicts a 'perfect' situation for coordination. The reality is that all these are not implementable or achievable to the fullest degree. There are situations where we have to 'sacrifice' some aspects of the ideals in order to move forward

I am skeptical about how our commitments can actually be put into practice. We all want to coordinate and collaborate but there are many barriers to doing so

Sometimes unexpected events may make it impossible to abide by agreements

Commitment is an individual decision, but actual implementation is collective, and that comes with it some apprehension, about team commitment

#### **\*Concerns about lack of implementation details**

Blueprint for project roll-out unclear

Who will be acting as the overall coordinator? Is it a person? Who? And organization? Which? I would like to see structure as to how coordination will be done, like an organogram for coordinators

We have individual deliverables. How will the performance evaluation system adjust to incorporate coordination?

Document agreements. No reservations about desirability but concerns about the level of detail to be documented and process of holding stakeholders accountable.

The agreement is very general. Needs to be filled in and worked out. How are we going to work with contextual factors, e.g. lack of time, HQ demands, conflicting personalities

Commitment, time

**\*Concerns about resources**

Challenge is time and money is need to coordinate and ????

Also, whether some partners hold more authority than others

Will all devote the necessary time?

Very difficult to get people together on a quarterly basis – and not much new data, make them semi-annual.

**3.3. Our vision: what we try to create collectively**

*“If you want to build a ship, then don't drum up men to gather wood, give orders, and divide the work. Rather, teach them to yearn for the far and endless sea.”* (Antoine de Saint-Exupéry)

- Productive partnerships (public-private)
- Synergistic action at all levels
- Community-focused strategies
- High quality and accessible services and products
- Community ownership of health interventions
- Quality of life improved for all

<b>3.4. Elephants on the road to the vision</b>				
<b>Ineffective planning</b>	<b>Conflicting priorities</b>	<b>Counter-productive mindsets</b>	<b>Missing links</b>	<b>Imbalance between goals and interventions</b>
Planning mechanisms are vertical and sectoral	Different priorities	The common good is often abused	Socio-cultural constraints affecting quality of life	Mismatch of training for the job
Inefficient system and use of resources	Public-private goals and objectives differ	Passive receptivity of community	Factionalism (lack of unity, ethnicity, political, “at all levels”)	Inadequate local capacity
Rivalry	Vertical programs	Community fatigue	Empowerment and ownership	Limited or weak coordination mechanisms
Mistrust (hidden agendas)	Inequity in the distribution of resources	Staff attitude impacts on quality	Leadership problems (ineffective, conflict of interest)	

<b>3.4. Elephants on the road to the vision</b>				
<b>Ineffective planning</b>	<b>Conflicting priorities</b>	<b>Counter-productive mindsets</b>	<b>Missing links</b>	<b>Imbalance between goals and interventions</b>
Inadequate time allocation by planners (participatory planning takes time)	Different approaches		Leadership	
Lack of participatory planning (top-down approach, lack of community contribution, lack of trust in project)	Variations in the understanding /interpretation of quality (standards)			
	Insufficient attention to community, sensitization Empowerment and mobilization			

**3.5. Addressing the common challenges, or: what are we currently doing or planning to remove these elephants?**

**3.5.1. Ineffective planning**

Currently working on this are GHS, GAC, NACP, DRI. Need to harmonize geographically and thematically.

**What we are currently doing or what are we planning to do:**

- Participation in regular coordination meetings (all key partners)
- Identify overlaps with key stakeholders and selected activities that will be done jointly
- Joint planning at all levels, break workplan by function and by geographical area
- Identify comparative strengths and allocate roles and document who is doing what with whom and where.
- Avail information, planning tools, data, etc. in a pool accessible to all
- Develop working groups across the domain of stakeholders, location, function (e.g. baseline workgroup, training workgroup, VCT workgroup, etc.)

Organize frequent sessions for joint dissemination and sharing of lessons, feedback, etc. (at all levels).

### **3.5.2. Counter-productive mindset**

Need for 'clinic' as a counterproductive mindset, CHPS-TA us working on this  
Help-rejecting complainers.

't is your fault we have run out of stock' mentality, Deliver is working on this by removing the middle person

Chef who takes lantern meant for common good

Fear of hijack/parachuting affects community ownership (research results never return)

In Agamanyo sensitize community involvement through wife of paramount chief

Fear the services will corrupt youth (FP/HIV) – EH is doing facilitative supervision, and counselor/staff training.

Community fatigue – CHPS-TA Community decision making system (puts community first)

### **3.5.3. Missing links**

GHS: sensitization of traditional leaders on program goals (eg HIV/ADS)

QHP/GHS: training RHMTs/DHMTs to become trainers

GHS, CHPS-TA, local governments, GSCP: community mobilization/sensitization for e.g. CHPS compounds

Local gov't, NCCE, ISD: conflict resolution campaigns/efforts.

### **3.5.4. Conflicting priorities**

#### **Who is doing what to remedy this?**

GPRS/C/SM target population associations

MOH – coordination mechanisms

GHPVOD - ?

GHANET – HIV network

#### **Ways to address this elephant:**

Monthly donor coordination meeting

MOH Private sector unit

Advocacy with GAC and NCAP (HIV prioritization)

Participatory planning at district and regional levels

Conflicting priorities in focus districts for projects

### **3.5.5. Imbalance between goals and strategies (interventions)**

#### **Who is doing what to remedy this?**

EH/AED/CHPS-TA: facility survey,

**Ways to address this elephant:**

Participatory planning methods (CDS, community COPE)  
Assessment of equipment, baseline assessment of HR, material resources, institutional capacity, curriculum  
Advocacy for behavior change at the policy level  
Health forum (national, regional, district)

**3.6. Areas of overlap and agreements on how to prevent or manage negative consequences**

**3.6.1. Training and training assessments**

(Participants in the group: HIV/AIDS, BCC/Quality, CHPS-TA, WorldEd, QHP)

**Inventory:** Will all be working in districts and regions  
All of us involved in training, capacity building (advocacy, clinical)  
We found some overlap (not surprising)  
Also duplication that USAID was not expecting us to have  
Question to USAID: who is supposed to be working at which level?

**Challenges and problems:**

Overlap  
Sequencing  
When CPHS is ready to work on training with CHOs, have the CHO supervisors already been trained in supervision by QHP?  
Coordination of training themselves as well as content  
Training overload for DHMTs  
Approaches to training: workshops versus on the job training  
GHS wants to see alternatives to workshop, dilemma is the need to reach a critical mass  
Interested in who is doing what and where  
Curriculum development for in- and pre-service training, realize need to call in other projects and review and/or comment, ie, BCC folks to look at behavior change materials

**Agreements/decisions/intentions:**

Facilitative supervision training will be done down to the district level (by QHP), except in CHPS zones, where the sub-district supervisor will be included. This person will then also be involved in the CHO training activities  
CHPS-TA will go back to the workplan and do some revising

**3.6.2. HIV/AIDS services**

(Participants: OICI, QHP, CM, NACP, USAID, GSMF, CHPS-TA)

**Inventory:** we all need to identify hi risks groups and develop interventions

Interventions around treatment, care and support, PMTCT, capacity building at various levels  
Working with the local structures  
Need supporting surveillance, biological surveillance  
QHP: look at quality of services, providers at VCT. Use guidelines and work with NACP, strengthen structures already existing  
AED: comm. Strategies for HIV/AIDS across all groups, including hi risk, development of materials, providing support for , communication around freestanding VCT sites; pilots for expansion  
OICI: food for peace, four regions in north, working with HIVE OVCs, work with traditional healers  
CHPS-TA: HBC and referrals to clinics

**Challenges and problems:** lots of overlap, in terms of regions and areas  
NACP: told us what already is going up and how we can support.  
Need to continue this discussion  
Worth looking at WB program (ART)  
Support for TRI, supported by Dutch with WHO  
For now conclusion: need for us to keep on talking, set up a coordinating meeting to further cement our working relationships

**Agreements/decisions/intentions:**  
Follow NACP guidelines on how to capture TB patients as part of HIV/AIDS programs  
ART sites start vertical. After one year they are integrated into the regular health system (supervision, supply, monitoring, etc.)  
PMTCT sites will function in an integrated manner from outset  
QHP will include OIs in their workplan

### **3.6.3. Community-level interventions**

(Participants in this group: CHPS-TA, AED, GHS, OICI, PHR+, CRS, Netmark)

**Inventory:** Community mobilization and entry, Capacity building, Advocacy and pre-service training. Lots of overlap

**Agreements, decisions, intentions:** have joint meetings, joint community entry programs, joint training, joint development of training materials  
Insufficient time, will continue the conversation in a meeting called by CHPS-TA (when?) to make some concrete proposals.

### **3.6.4. Organizational support (and infrastructure) for capacity building**

(Participants in this group: EH, CHPS-TA, Deliver, USAID, AED)

**Inventory:**  
We all need to know the baseline, what kind of facility is this, where are the lapses in terms of infrastructure and HR, and logistics. We will do a baseline to get all these things so that we empower the people returning from training.

**Specific contributions:**

EH: baseline survey assessment of infrastructural needs; assessing capacity of service providers (limitations); strengthen institutional capacity at national level (in-pre-service training); quality assurance standards and protocols; infrastructural development at local level to utilize services.

CHPS: logistics support for setting up community based service delivery (CHO, CHC); strengthening Training School (pre-service) revision of curriculum; assessing other Navrongo initiatives (Nursing training school) workers for application (implication??); redoing job descriptions of CHO and inservice training; advocacy at policy level to introduce changes in CHO training requirements/curriculum

AED: needs assessment; quality assessment of couple/years protection

Deliver: services/products) commodities security; study on willingness to pay for services (PP); capacity building of social marketing issues for contraceptive procurement; capacity building at central level to secure essential drugs and FP (integrated approach); standard procedures for managing ART; set up SS system for HIV/ART other drugs; (vertical approach central level to facility level)

**Challenges and problems:** deliver will supplies in FP and other drugs, building capacity of marketing organizations to do the same. issue of credit, affects stock level; propose try to make sure that every level in the delivery process there is stock for 2 months. Attrition. Supplies for collecting data.

**Agreements, decisions, intentions:**

Look at who is doing (infrastructure/equipment) baseline where and combine, streamline, consolidate between us.

Synchronize equipment and commodities supply with immediate post-training

Link up with DAs for assistance (support (common fund)

Involve communities in planning activities and executing them, then monitoring and evaluating

Community contribution to increase

Have a markup on FP commodities, communities or vendors retain portion to continue running the program

General monitoring of activities

**3.6.5. Monitoring & Evaluation**

(participants in this group: HIV/AIDS, PHR, GHS, USAID, AED, CHIPS-TA)

**Inventory:** looked at two different types of M&E activities: (1) Evaluation issues focusing on baseline and (2) Routine monitoring. We identified specific activities to collect data we need: using existing sources form GHS and regional sources, DHS, some of our own surveys, facility based survey (QHP), took inventory of these events and see where there is overlap, how we can combine. GHS mentioned data sources we might use that we didn't know about.

HIV/AIDS: survey CSWs in Kumasi and Accra (WAPCAS)

MOH/GHS: reviewing health sector indicators and targets (this Friday 9/24)

GSCP: National (using DHS) – district comparative surveys (interv. Versus non interv. Districts). Formative research on constraints to health-seeking behavior; district/regional/national annual reports.

PHR+: Assessing impact of health insurance law on selected districts (collaborate with GHS); census of MHOs.  
CHPS-TA: district MIS annual data from 28 target districts; CHPS M&E database (PPME); district and community-level surveys to address gaps  
QHP: Facility baseline survey (infrastructure, staffing, provider interv. and observation, client exit interview; rapid assessment of HRM systems and resources

The things we look at for regular monitoring: common indicators (reg. and other), training numbers (numbers of people trained and service delivery performance), sales of commodities (contraceptives, ITNs), media monitoring, reg. data collection from the facilities (VCT, PMTCT, ART, etc.), preceptors and CHOs trained; CHOs deployed; number of CHVs.

**Problems and challenges:** data quality, using existing sources, extent to which existing data sources are disaggregated as we need them  
Inclusion of VCT centres and STI-PMTCT clinics in facility baseline survey; overlap of data collection activities (also an opportunity)  
Needs for Cap building of related institutions, and even our own  
M&E in the private sector is more challenging, especially for profit which may fall outside our mission.

**Agreements, decisions, intentions:**

We will create a M&E workgroup that will come together periodically to talk about these issues/reach agreement on common ground. Joseph will call a meeting by mid October  
Build up internal M&E capacity  
Study GHS report on data quality

### ***3.7. Looking at the work geographically***

The placement of post-It Notes on the charts for each level and region revealed (even though not completed by all):

**Observation**

1. Enormous amount of work planned with national level (various units)
2. Various TOT initiatives targeting the same regional trainers
3. Regions 1,4,5 and 10 have the most activities planned involving a regional presence, and similar districts

**Agreements**

CHPS-TA and QHP will meet soon and review workplan to find complementarities and resources in R10 districts

SCP/GHS collaboration on baseline/design of instruments

HIV/AIDS actors will meet to coordinate HIV/AIDS issues before mid October

GHS requests flexibility as they will take the national level activities chart back to their people

Meeting is called by CRS/HIV/AIDS project to talk about care and support in the districts regarding target population. Invitees are: OICI, CRS, AED

Those who have issues with the overlapping Indicators chart will talk with USAID within the next week to talk things over and reach agreement

Next coordination meeting will be hosted by QHP at their offices. The meeting will be at most one day, requiring one representative per group, less ‘formal’ (and less stressful). Focus will be on how well the agreements have been working and making changes if needed, in addition to a review of the next quarter activities. The meeting is planned for mid January, more details to follow later.

Inclusion of some ‘measure’ of coordination in the M&E plans/reports.

C/M Project will contact individual projects to get more clarity on their priorities

**Issues raised for later consideration:**

“We are just four!” and concern for overload from GHS point persons

Clarification and review of CHPS-TA indicators.

**3.8 Requests**

<b>Requests</b>	<b>Replies</b>
<b>From USAID (request)</b>	<b>To bilaterals (reply)</b>
Need to be regularly informed (min 2xmonth) on respective CA’s progress	Agree
Would appreciate agendas 2 to 3 days in advance of the meetings between USAID and bilateral	Agree
Willing to use national curricula for all interventions (comm. entry, TOT, Fac Spv? How will this be decided?	Yes, however, want to retain the possibility of review and revision. Agree to talk with USAID before doing so
In order to meet our commitments to GHS/DGs, please submit your tallies for consolidated workplan by October 15	Compromise accepted. (NB: Post-In Note version of consolidated workplan is being typed at USAID and will distributed to all for filling in missing information that is already known)
Help us get our reporting out on time by timely submission of your reports/data	Agree
Your key contact at USAID is your CTO, please make sure to go through your CTO and keep him/her informed	OK
<b>From USAID (request)</b>	<b>To ‘others’ (minor CAs) (replies)</b>
Are CRS and OICI willing to use CHO	Agree

<b>Requests</b>	<b>Replies</b>
curriculum for their CHPS zones and national CHPS approach?	
Are CRS and OICI willing to map out their zones for CHPS and share with CHPS-TA and USAID?	Agree by mid October
Can you participate in regular meetings (for productive coordination) as appropriate?	OK, every other month
In the spirit of coordination would appreciate copies of non-bilaterals progress reports	OK
<b>From ‘others’ (request)</b>	<b>To USAID (reply)</b>
Would like to know more about reporting format for USAID	Draft format will be circulated before mid October; progress on indicators and benchmarks versus expectations and why
Let’s see what we can do about funding PHR+, possibly let’s re-strategize and focus on common goals	<b>Will be address in another setting</b>
Excellent organization of collaboration between NGOs/PVOs. Please take the responsibility to sustain such collaboration	Thank you. Will have 4erly meetings
<b>From ‘others’ (request)</b>	<b>To bilaterals (reply)</b>
Would like to participate in inter-agency coordination committee for contraceptive security meeting (ICC/CS)	Come to ICC/CS meetings , AED-BCC and GHQ will attend, please keep informed of meetings
Continued information flow between partners; info sharing between partners; invite us t relevant coordination meetings	All relevant organizations will be invited to relevant meetings; also receive quarterly newsletters
<b>From ‘others’ (request)</b>	<b>To GHS (reply)</b>
Facilitate administration and protocols for the implementation of partners’ workplan	GHS will examine consolidated workplan and coordinate through point persons, also will be negotiated between CA’s and relevant counterpart units
<b>From bilaterals (request)</b>	<b>To GHS/MOH (reply)</b>
Mapping out who is doing what (USAID health partners and other donors)	Each bilateral will discuss w/ GHS but final or progressive mapping will be done by bilaterals in agreement with relevant GHS level. Also DHMTs will have this info
More clarity on geographic coverage	We have been discussing for 2 years. DG says stick to 28 for now
Clarity on role of point person and link with others at GHS	Point person will delegate representation and authority at all times
Clear, transparent, consistent and timely communication on how things are going (positive and negative feedback)	Focal persons will be forthcoming at all times, regional/district staff should be made aware also.

<b>Requests</b>	<b>Replies</b>
<b>From USAID (Request)</b>	<b>To GHS/MOH (reply)</b>
Regular briefings with point person (1x per month?);	<b>Suggest once per three months. There was no agreement on this, needs to be further negotiated</b>
We have requested a point person for contraceptive security/logistics, can we have some follow-up?	Cynthia will follow up with DG. Give her 2 weeks
Can we be copied on or informed on progress reporting to the DG?	DG has proposed 4erly info meetings between GHS/USAID/bilaterals. Non bilaterals would like to be included, Irene will send list of names and addresses to Cynthia
<b>From GHS/MOH (Request)</b>	<b>To bilaterals (reply)</b>
CAs to find innovative ways of training, like OJT, study tours, attachments	Yes, have innovatve approaches like WST (QHP), District-to-district exchange (CHPS-TA); GSCP, training link to implementation; We are open to more
Flexibility of CA workplans to fit GHS national, regional and district plans	Agree, will plan with GHS and will be flexible within constraints of cooperative agreements ('life happens!')
CA team leaders to participate in Health Summit	OK
Develop code of conduct to guide CA operations	Clarification requested. Reply from GHS: there is a document and Cynthis will find it and share it with CAs
Reporting on funding activities: develop common format for financial reporting, regions and districts will retain receipts for auditing purposes; reporting format completed and send to agencies after activities completed	If there is a subagreement the receipts stay at district level; if not receipts need to go to agency. Changing the format is not that simple and will take time to discuss with HQ. GHS will send a format for financial reporting used by districts to CAs by October 8 to consider and discuss with their HQs
Funding – sign MOUs with CAs	<b>Cynthia will set up meeting to discuss.</b>
<b>From bilaterals (Request)</b>	<b>To “others’ (reply)</b>
Form issue-focused working groups among bilaterals and other projects	OK. Groups being considered for Care/Support; CB; BCC for specific targets;M+E, etc.
More clarity on linkages and working together	It takes time; the working groups will help. Also quarterly coordination mtgs, annual planning and coordination mtgs, mutual progress report sharing
<b>From bilaterals (request)</b>	<b>To USAID (reply)</b>
Request extension of workplan submission to November 1 to digest this meeting	COB October 15 is compromise
Request a review and renegotiation of	<b>To be arranged by CTO at another time</b>

<b>Requests</b>	<b>Replies</b>
outcomes and indicators by CHPS-TA and GSCP	
Dissemination of bilaterals' work at donor meetings	Will be done
More clarity on geographic coverage	QHP still has some questions, will be discussed in separate meeting
Mapping on who is doing what where	Usaid is doing this but needs input from consolidated workplan
<b>From GHS (request)</b>	<b>To USAID (reply)</b>
Use GHS auditing system (auditor general and private firms, should USAID want to appoint a new audit firm?)	Explanation that this is not within scope of authority of health team but willing to facilitate. Request needs to come from the MOH and USAID needs to consult with Regional Inspector General in Dakar, so this is not a simple issue. Ursula will talk more about this with DG
Funding mechanisms should channel through GHS Acctg HQ with copies of letters to regions and districts	Will examine the options. DG to dialogue with health team
How will you support/help us to make districts more attractive to health providers (a question about incentives)	Our support is limited to performance management.
4terly coordination meetings with DG and heads of division departments	DG calls meeting. OK (this is not the DG/COP/other partners meeting)
Flexibility of workplan to fit national, regional and districts activities	Agree in principle but too vague a request. Will discuss on a case by case basis

### **3.9 Agreements on how to handle breakdowns (in communication or when agreements made are violated)**

When you have a problem with another person or team, please come and talk (no emails, and certainly no emails with lots of people cc-ed)

Don't take things personally

Be honest with each other (say what you mean and mean what you say)

As a matter of routine, put the discussion of snags (challenges, breakdowns) on the agenda when you meet again, ask 'how are we doing as a group?'

## 4. Documents used in the facilitation

### 4.1. Context in which coordination takes place

<b>Helping factors</b>	<b>The challenge of working together</b>	<b>Hindering factors</b>
Fresh start for many Lots of goodwill Commitment to make a difference Expertise All from the same 'extended family' (common mission) Lots of local staff		Headquarter history Loyalty to multiple clients some with more power than other, and existence of conflicting needs and instructions Imperative of looking good and competent, concern about who gets the credit for success, blame for failures? External pressure not under one's control (politics intruding) Territoriality (this is my turf, technically or geographically)

### 4.2. Group norms

(Adapted from Project Adventure facilitators manual, Beverly, MA)

#### **Speak your truth, which means:**

- share honestly with a spirit of inquiry
- steer clear of blame and judgment
- speak forthrightly but respectfully and realize your truth may not be someone else's

#### **Be open to outcomes, which means:**

- suspend judgment
- take the risk that you might change your mind

#### **Be present, which means:**

- no other (outside) business
- decide what you want to do if you don't want to be here
- turn off cell phones
- be on time

#### **Pay attention, which means:**

- not just hearing words spoken
- listen for full message before launching into response or rebuttal
- what's going on inside yourself

### 4.3. When there is negative past history

Some people come to a planning or coordination exercise with an attitude of "been there done that," having already judged and evaluated the experience and having all sorts of opinions about what will happen. In addition, many people who come together in groups have some past experiences with each other. If these experiences were positive then you are ahead of the game. But if these have been bad, you have an extra challenge. Ask the group to make a commitment to create a safe place together. Ask them to 'try' mastering the art of forgiveness. This is partially out of self protection for the facilitator but also to keep the whole group learning. As soon as people start pointing fingers, blaming, or talking behind people's backs, or defending themselves, the learning stops. Forgiveness allows a group to continue collective learning and find out together what forces are keeping them away from their goals, or what contributed to unexpected outcomes. Forgiveness also means not holding mistakes as a trump card to use in the future when organizational politics seem to encourage this.

### 4.4. The language we use

*"All problems I have with my fellow men stem from two things: I don't say what I mean and I don't mean what I say." (Martin Buber)*

*"Watch your thoughts; they become words. Watch your words; they become actions. Watch your actions; they become habits. Watch your habits; they become character. Watch your character; it becomes your destiny." (Frank Outlaw)*

<b>Reactive language</b>	<b>Proactive language</b>
There's nothing I can do	Let's look at what we can do
That's just the way I am	I can be different
He (She) makes me/ so mad	I decide how I feel
They won't allow that	May be we can negotiate
I have to do that	I choose to do what is appropriate
I can't	I choose
I must	I prefer
If only	I will
You should	Would you be willing ?

*Adapted from Stephen Covey : The Seven Habit of Highly Effective People, 1989 :78*

#### 4.5. Three dimensions of human behavior in relation to others

Summary from Will Schutz. *The Human Element*. San Francisco: Jossey-Bass Pubs, 1994.

In our relationships with others we have a choice how to behave. Will Schutz identified three dimensions: (1) The degree to which we include or exclude ourselves in our relationships with others. (2) The degree to which we control or submit to other people's control. (3) The degree to which we open up or remain closed in our relationship with others.

Our choice is influenced by both rational and irrational motivates. My preference for contact with others is a rational motive, and so is my need to have some control over my life, and my need to have some degree of openness in my interactions with others. This rationality allows me to adapt my behavior to the requirements of the situation. For example, I can choose to include myself in a group or exclude myself. There may be good reasons to do either. Or I could decide to take a leadership role in one situation and be a follower in another. And finally, I am probably more open in my relationship with my spouse than I am in my relationship with people I don't know in a business meeting. When rational motives prevail, I can choose how I will behave.

The irrational motive is fueled by my defensiveness (my anxiety about inclusion, my fear of being helpless, and my fear of being rejected, unloved). This defensiveness causes rigidity in my behavior, and thus results in inappropriate behavior when I cannot adapt to changing circumstances. I am mixture of these rational and defensive aspects. How the mixture turns out depends on how I feel about myself. The healthier my self-esteem and the greater my self-awareness, the stronger the rational motive, and the greater my range of choices.

##### **Inclusion and interpersonal relations**

Issue	In or out
Behavior with others	Inclusion
Behavior towards self	Aliveness
Underlying feeling	Significance
Interaction	Encountering or meeting
Interpersonal fear	Being ignored or abandoned
Personal (existential) fear	Being insignificant, unimportant, worthless

##### **Control and interpersonal relations**

Issue	Top or bottom (dominance)
Behavior with others	Control
Behavior towards self	Self-determination, choice
Underlying feeling	Competence
Interaction	Confronting
Interpersonal fear	Being humiliated, embarrassed, vulnerable
Personal (existential) fear	Being incompetent, incapable, phony

## Openness and interpersonal relations

Issue	Open or closed
Behavior with others	Openness
Behavior towards self	Self-awareness
Underlying feeling	Likability, lovability
Interaction	Embracing
Interpersonal fear	Being rejected, disliked, despised
Personal (existential) fear	Being unlikable, unlovable

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