



# How to

# Mobilize Communities for Health and Social Change



A Field Guide by Lisa Howard-Grabman and Gail Snetro



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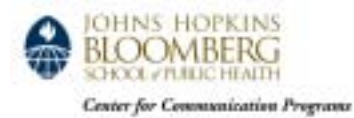
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[Inside back cover]

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# Introduction

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“Before we were careless and almost never spoke of the problems of the community. Now it is different; we can do our part and everyone with their opinions can improve the system and the conditions of living”

Community Health Promoter, Bolivia

## Community Mobilization and Social Change

The growing body of evidence in the international development field repeatedly demonstrates that communities can make deep and lasting contributions to their own health and well being—and, through example and imitation, to the health and well-being of other communities. Consider:

- In Bolivia, 50 poor, isolated communities cut newborn mortality by more than half in three years. Families adopted many healthier practices, developed emergency transport and financial support systems, and, most importantly, increased women’s participation and status in community decision-making. This community mobilization approach was later expanded to over 500 communities in Bolivia and was adapted for use in many other countries. (*The Warmi Demonstration Project, 1990-1994*)
- In Vietnam, communities improved children’s nutritional status by learning from their own residents what existing local foods and practices could lead to healthy nutritional status. This “positive deviance” approach not only improved participating children’s nutritional status, but years later their younger siblings were also found to have good nutritional status. Neighboring communities learned how to apply the positive deviance approach through “Living Universities,” and it is now being used in a number of other countries and also being applied to other health issues. (*The Poverty Alleviation and Nutrition Project (PANP), 1991-1993*)

- In the Philippines, communities used “Appreciative Community Mobilization” to improve family health. Building on their own assets, strengths, and experience, community leaders changed the way they made decisions to allow for the participation of the community’s “priority families,” those whose health and other indicators demonstrated that they could use more community support. These communities subsequently reported improved child health indicators and increased use of family planning methods. Significantly, participating communities also learned how to access municipal resources, advocate for policy changes, and monitor their progress. (*Kalasugan Sa Pamilya-Appreciative Community Mobilization Project, Iloilo, 1997-present*)
- In rural Peru where services were underutilized and a large sociocultural gap existed between service providers and community members, service providers and communities came together to jointly define “quality of care” and improve health services according to this joint definition. Relations between providers and communities greatly improved, Ministry of Health staff reported increased utilization of services, and clients reported greater satisfaction with the quality of care. (*Building Bridges to Quality methodology, 1998-present*)

**Community mobilization builds confidence. And when communities start believing in themselves, they become inspired to act.**

### **Advantages of community mobilization**

In the examples cited above, and numerous others, community mobilization has not only enabled communities to solve specific health problems, but more importantly, it has strengthened the underlying capacity of communities to identify and address other pressing needs. Examples of such capacity-building dividends include:

- Communities have generated and contributed additional resources that may not be available to the health system alone.
- Communities have learned how to apply political pressure to improve services.
- Empowering approaches have strengthened community members' ability to address many underlying causes of health problems, such as discrimination and prejudice, poverty, isolation, lack of a voice in policy decisions, and resource allocation.
- Community mobilization has helped to facilitate changes in social strategies, structures, and norms to increase access to information and services for those who need them most.
- Community mobilization has increased community members' awareness of their right to decent treatment and has strengthened their ability to claim this right.

In short, community mobilization builds confidence. And when communities start believing in themselves, they become inspired to act.

Community mobilization is not the best strategy for all health programs, of course, and you will need to determine whether it is appropriate in your circumstances. If



you have only six weeks to implement a program, for example, and your goal is to reach many people with a very specific message, you may conclude that taking the time to invest in relationship building and strengthening community capacity, in spite of the obvious long-term payoff, is not realistic. In this case, you may opt for a community outreach strategy led by health professionals or others with community participation but probably not ownership.

Community mobilization is particularly appropriate when:

- You are able to commit to working with communities for *at least* a year or two (particularly when community members and groups have not had prior experience working together).
- Systemic changes or changes in social norms are needed at the community level to support long-term health improvements.
- Sustained community support is desired.
- The health issue is too politically sensitive to be the thrust of a major public campaign.
- The settings are diverse and local solutions are required.
- The communities themselves have identified a health need and request assistance.
- Community resources are required or desirable.

## The path to social change—the Community Action Cycle

In the examples given earlier, the communities followed a process known as the Community Action Cycle that draws on many of the theories and concepts of a *social systems* approach to individual change and social change. This approach has been defined as “a process of public and private dialogue through which people define who they are, what they want, and how they can get it<sup>1</sup>”. While there are numerous models of how social change comes about, they all share certain fundamental elements—which are also the guiding principles of

**“Given that the major determinants are societal, public health must be committed to societal change.”**  
*Jonathan Mann*



<sup>1</sup> Grey-Felder, D., and Dean, J. (1999). Communication for Social Change: A Position Paper and Conference Report. New York: Rockefeller Foundation Report.

**The best outside assistance may be that which is put at the disposal of insiders**



community mobilization as presented throughout this manual. These are:

- Sustainability of social change is more likely if the individuals and communities most affected own the process and content of communication.
- Communication for social change should be empowering, horizontal (versus top-down), give a voice to the previously unheard members of the community, and be biased towards local content and ownership.
- Communities should be the agents of their own change.
- Emphasis should shift from persuasion and the transmission of information from outside technical experts to support for dialogue, debate, and negotiation on issues that resonate with members of the community.
- Emphasis on outcomes should shift away from individual behavior to social norms, policies, culture, and the supporting environment.

For years, the international development community has conceded that the very notion of “outside assistance” is problematic—and may even be a contradiction in terms. At the very least, outsiders, by definition, often don’t understand enough to be able to offer locally appropriate assistance. Or, to put it another way, the best outside assistance may be that which is put at the disposal of insiders. Throughout this field guide, we emphasize the importance of defining the role of external community mobilization program teams in relation to community groups. For the most part, this role will be focused on facilitation and accompaniment. Defining and redefining more specific roles will be one of your greatest challenges as you work with communities to help them address their changing needs as their capacity and autonomy grow.

To mobilize communities effectively, you don’t need to know all the answers. In fact, it is much better to be humble and admit from the start that you’re a learner

among learners. But as a facilitator, it is important that you pose key questions and help participants feel safe enough to explore and develop their own questions and answers. This process requires you, your team, and the communities you work with to carefully think about and plan how to proceed before you act, take the time to reflect on what you are learning, and then apply what you are learning to future plans and actions.

Along the way, flexibility and a willingness to challenge assumptions, sometimes make mistakes, learn from experience and adjust your approach accordingly will be critical to your success. Effective work with communities requires not only a thorough understanding of the various phases and steps of mobilization but also a strong commitment to, respect for, and belief in the abilities and potential of the people you aim to serve.

## How To Use This Field Guide

This field guide has been designed to be used by health program directors and managers of community-based programs who are considering using community mobilization to improve health at the individual, family, and community level. It may also be useful for directors and technicians in governmental and nongovernmental organizations working in public health and human development and other groups and organizations committed to community health, such as churches, universities, philanthropists, and donors. No prior community mobilization experience is required to use the field guide, but any experience that you have will enhance your understanding.

The field guide contains illustrative examples and lessons learned in community mobilization experiences from around the world, focusing on working with disadvantaged or marginalized groups in developing countries. The characteristics of each country and each region are very different, so the field guide does not recommend a unique strategy for community mobilization but offers instead general principles and methods which will need to be adapted to local settings and conditions.

This field guide will help the user:

- Examine and come to understand the philosophy, definition, and key elements of community mobilization as a strategy to improve health and increase community capacity to address health and other community needs.
- Learn about a variety of community mobilization methods and approaches and how they have been applied in different developing country settings.
- Develop community mobilization strategies and approaches.
- Implement, monitor, and evaluate community mobilization programs.
- Expand successful mobilization approaches to achieve greater impact.

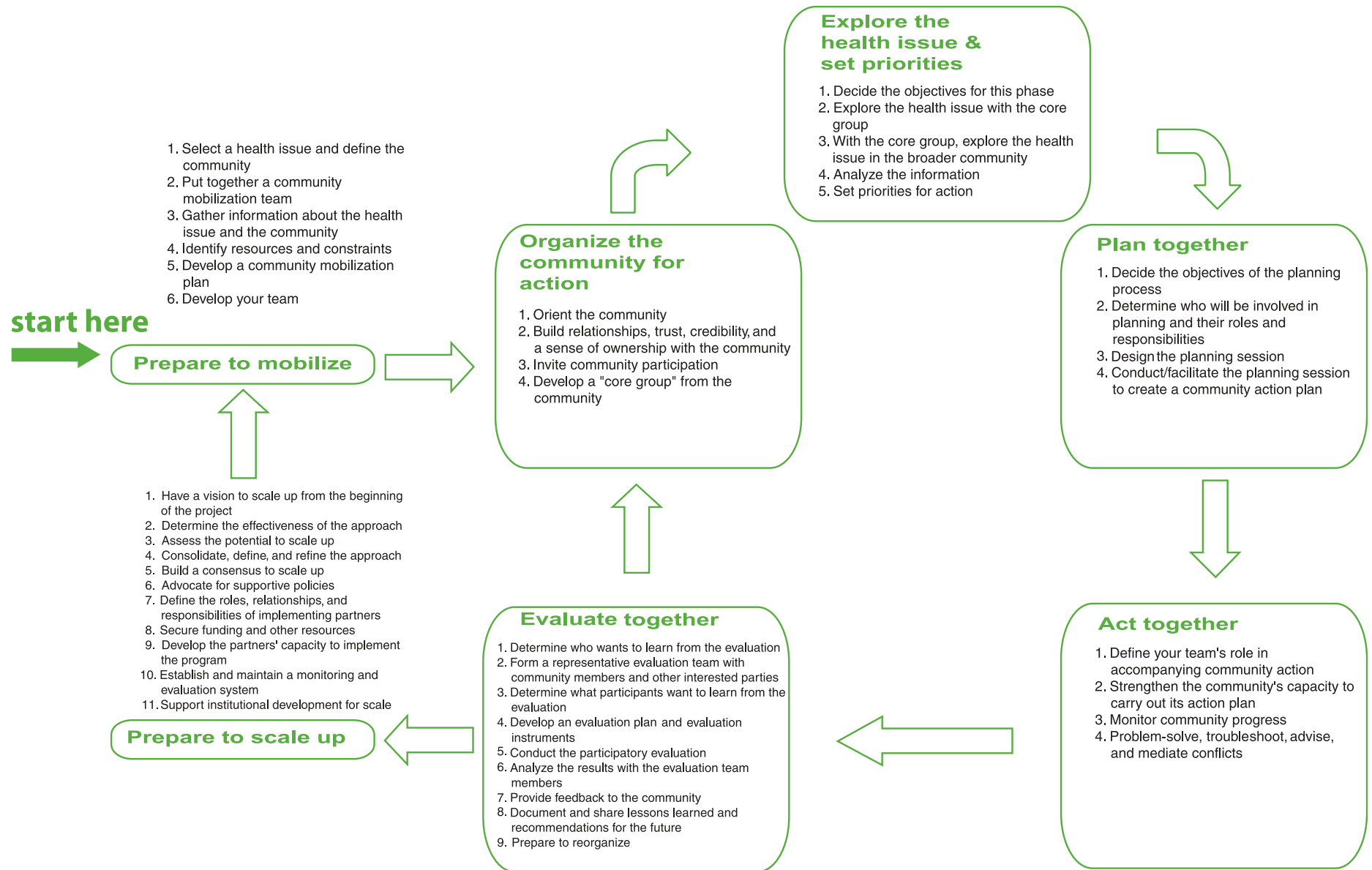
It is important to keep in mind that no written resource material can provide everything that your team will need to carry out effective community mobilization programs, particularly if your team has not had experience in this field. The field guide was developed as a practical resource to complement training and technical assistance.

### **How is this field guide organized?**

The field guide is organized around the phases of the Community Action Cycle:

- Chapter 1: Prepare to Mobilize
- Chapter 2: Organize the Community for Action
- Chapter 3: Explore the Health Issue and Set Priorities
- Chapter 4: Plan Together
- Chapter 5: Act Together
- Chapter 6: Evaluate Together
- Chapter 7: Prepare to Scale Up

# COMMUNITY ACTION CYCLE FOR COMMUNITY MOBILIZATION



## Icon Key:

Throughout this field guide, icons will appear to help you navigate the different forms of information:



**Country case study**



**Example**



**Tool or worksheet**



**Reference to  
Useful Tools section**



**Questions to ask  
before starting a task**

The chapters, one for each phase of the Community Action Cycle, are organized according to the steps in that particular phase. While the order of these steps reflects our experience, you may find that you need to adjust the sequence somewhat to suit your particular circumstances. At the end of each chapter, you will find a section entitled Useful Tools that includes worksheets, guides, and other materials, as well as a list of resources you may refer to for additional information.

We suggest that you first read through the entire field guide to familiarize yourself with the content in each chapter. Then you can focus on individual chapters as you need them during your own program implementation.

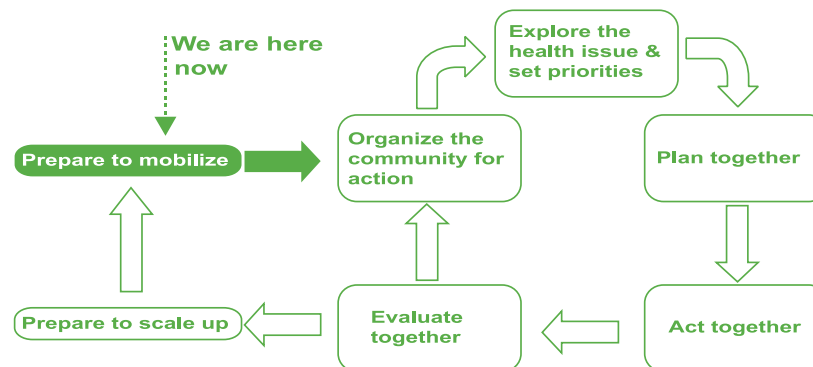
This “how to” field guide, the result of decades of work in the field, is admittedly still evolving, a work in progress that can be improved through the exchange of ideas and experiences. We have tried not to be prescriptive but to offer general steps, tools and approaches that many effective community mobilization programs have found useful.

We would like to warmly thank all of the many wonderful, committed people who helped us along this journey by sharing their experiences, lessons, insights, humor, and support. We have tried to credit our colleagues for all the examples and resources throughout the field guide and sincerely apologize if we have unintentionally omitted anyone.

# Chapter 1

## Prepare to Mobilize

1. Select a health issue and define the community
2. Put together a community mobilization team
3. Gather information about the health issue and the community
4. Identify resources and constraints
5. Develop a community mobilization plan
6. Develop your team



# “Sustainability cannot be assured without the participation of the people.”

B. Bhatnagar, et. al., “Participatory Development and the World Bank,”  
World Bank Discussion Paper

Community mobilization is a proven development strategy that has helped people around the world identify and address pressing health care issues. Community mobilization not only helps people improve their health and living conditions, but by its very nature

strengthens and enhances the ability of the community to work together for *any* goal that is important to its members. The end result of a successful community mobilization effort, in other words, is not only a “problem solved” but the increased capacity to successfully address other community needs and desires as well.

Among other benefits, community mobilization efforts can:

- Increase community, individual, and group capacity to identify and satisfy their needs
- Improve program design
- Improve program quality
- Improve program results
- Improve program evaluation
- Be a cost-effective way to achieve sustainable results
- Increase community ownership of a program

Like any development approach, community mobilization is not a panacea; it’s not the answer to every development issue nor the right approach for every community. And even within the same community, it may be the right approach for certain health issues but not for others. In the right circumstances, however, it has been proven to be a powerful tool for unleashing the potential of individuals and communities around the world.

## What is community mobilization?

“Community mobilization” has been used to describe a range of community-





based activities—from community members marching in the streets with signs at the request of the Ministry of Health to raise awareness of a health problem to a much more sustained process in which community members participate in all aspects and phases of a health program. Throughout this field guide, we are using the following definition that is closer to the second scenario:

**Community mobilization is a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.**

Expanding on this definition somewhat, we can list the key tasks involved in most successful community mobilization efforts. In general, community mobilization involves:

- Developing an ongoing dialogue between community members regarding health issues.
- Creating or strengthening community organizations aimed at improving health.
- Assisting in creating an environment in which individuals can empower themselves to address their own and their community's health needs.
- Promoting community members' participation in ways that recognize diversity and equity, particularly of those who are most affected by the health issue.
- Working in partnership with community members in all phases of a project to create locally appropriate responses to health needs.





## Key Elements of Community Mobilization

The following lessons learned by an HIV/AIDS Care and Support Initiative in Malawi capture many of the key elements of community mobilization:

- Community mobilization is a mechanism to define and put into action the collective will of the community rather than a mechanism to achieve community consensus for externally defined purposes.
- The mobilization process should unfold according to an internally defined rhythm where the community is left to progress at its own pace and in its own time. Emphasis should be on a process that is iterative and incremental.
- Any outside support should be aimed at building the capacity of communities rather than merely delivering services. The external organization's role should be to sensitize, mobilize, and build capacity. Outside supporters can catalyze the process in a somewhat systematic fashion, but neither they nor funding bodies should dictate what specific actions a community eventually decides to undertake.
- The timing of outside support is crucial. Leading with outside resources before a community begins to take action through internally produced means is a sure way to subvert local ownership and responsibility.
- Committees [or groups] that are able to mobilize the entire community's involvement in carrying out activities become the most dynamic and are able to sustain motivation over the long run. A group that assumes responsibility for addressing problems on behalf of its community is likely to burn itself out.

*Save the Children. COPE/Malawi Community Options for Protection and Empowerment Project.*

- Identifying and supporting the creative potential of communities to develop a variety of strategies and approaches to improve health status (even interventions that may not have been recommended by funders and other external actors).
- Assisting in linking communities with external resources (e.g., organizations, funding, technical assistance) to aid them in their efforts to improve health.
- Committing enough time to work with communities, or with a partner who works with them, to accomplish the above. Normally, this process is not suitable for short-term projects of less than two years.

It may also help to explain what community mobilization is *not*. It is not a campaign, for example, nor a series of campaigns. Nor is community mobilization the same as social mobilization, advocacy, social marketing, participatory research, or nonformal or popular education. Although community mobilization often makes use of these strategies, these terms are not synonymous. (See the Glossary at the end of the field guide for definitions and information on these and other related terms. Also see Useful Tool V at the end of this chapter for a list of “key elements of community mobilization” to discuss with your team.)



## The role of external organizations

A recurring theme in the literature and practice of community mobilization is the proper role of external organizations. In some cases, community mobilization is both prompted and carried out exclusively by community members. More often, however, mobilization is a collaboration between the community and one or more external organizations, which may be local, national, or international and either private or governmental. In many cases, an outside organization is the impetus



for or catalyst behind a mobilization effort. External organizations often bring important elements to the table, such as technical expertise, broad experience, financial resources, or simply an outside perspective that may be lacking in the community.

While conventional wisdom among community development workers has long held that we should mobilize communities around their felt needs, certain health problems are not perceived by the community or not considered priorities, for various reasons:

- The problem may be perceived to be the norm (e.g., stunting from malnutrition).
- The problem may be a silent epidemic, such as HIV/AIDS.
- The problem may be experienced by those in the community who have little or no voice in community decision-making (e.g., social castes, the poor, women, the geographically isolated).
- The problem may be associated with social stigma and/or fear (e.g., STIs).
- The community believes that no solutions are within its reach.

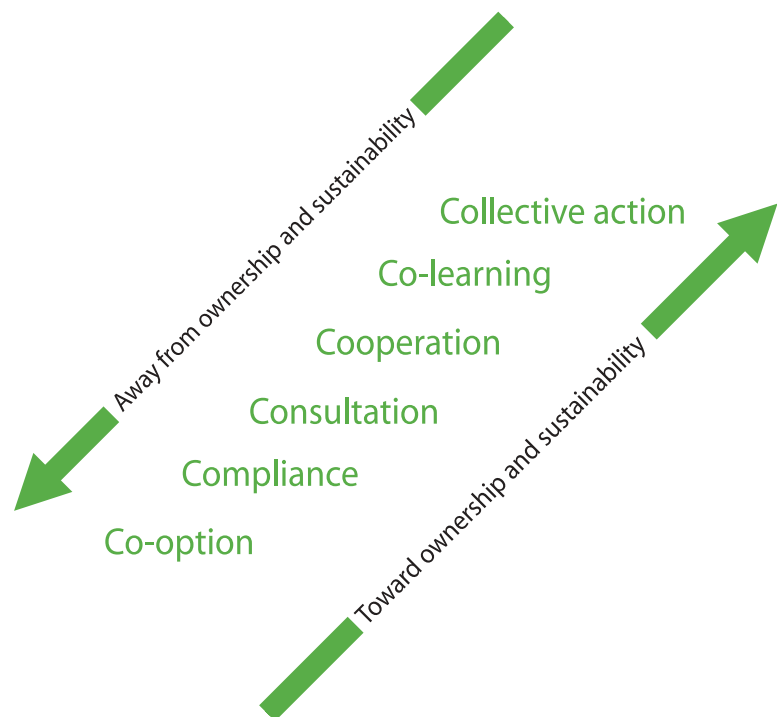
In these situations, external organizations play an important role by helping community members raise awareness about these problems and build momentum in the community towards the development of sustainable solutions.

Community mobilization efforts are no less authentic when they involve outside players—and are often more effective—but all those involved must be careful to ensure that the role external organizations play does not undermine one of the key goals of mobilization: building community capacity. In general, as long as the role of outside players is confined to advising, facilitating, and supporting the work of community members, participation by outsiders can be very beneficial. It is only when external actors begin to direct or manipulate the effort that the building of community capacity is potentially compromised and sustainability is undermined.

**More often, mobilization is a collaboration between the community and one or more external organizations, which may be local, national or international and either private or governmental.**

The following graphic illustrates the relationship between the various degrees of community participation and the resulting sense of ownership and prospects for sustainability.

## Degrees of Community Participation



Adapted from: Andrea Cornwall, 1995, IDS

### Degrees of Community Participation<sup>1</sup>

**Co-option:** token involvement of local people; representatives are chosen, but have no real input or power

**Compliance:** tasks are assigned, with incentives; outsiders decide agenda and direct the process

**Consultation:** local opinions are asked; outsiders analyse and decide on a course of action

**Cooperation:** local people work together with outsiders to determine priorities; responsibility remains with outsiders for directing the process

**Co-learning:** local people and outsiders share their knowledge to create new understanding and work together to form action plans with outsider facilitation

**Collective Action:** local people set their own agenda and mobilize to carry it out, in the absence of outside initiators and facilitation

<sup>1</sup>Cornwall, A. (1996). "Participatory Research Methods: First Steps in a Participatory Process", chapter 9 in *Participatory Research in Health: Issues and Experiences* (de Koning, K. and Martin, M., eds.), London and New Jersey: Zed Books, Ltd.

In the best cases, community members enter into a dialogue within their community and with external actors to explore ways to improve their health. Through this dialogue, effective community mobilization strategies acknowledge and respect indigenous health paradigms while at the same time introducing other paradigms, such as a biomedical perspective. While we know from epidemiology, for example, that certain behaviors can lead to improved health status, simply prescribing these behaviors is not likely to lead to adoption or sustained practice if they conflict with existing indigenous practices and values. In some cases, prescribed behaviors may not be possible or practical in a given physical, social, cultural, psychological, or economic context. In others, traditional practices may be as, or more effective, in improving health status. Through a respectful dialogue between all the parties, both existing and new paradigms can contribute to new, improved health practices at the individual level and supportive policies at the institutional, community, regional, and national levels.

At all seven stages of a mobilization effort—initial preparation, organizing the community for action, exploring the health issues and setting priorities, planning, acting, and evaluating together, and scaling up—external players need to keep in mind a simple rule of thumb: community mobilization is not just something done *to* the community but something done *by* the community.

## STEP 1: Select a health issue and define the community.

One of the first things that happens in any community mobilization effort is the selection of a health issue around which the community will eventually mobilize. Ideally it is the community itself which selects the issue, but in the real world of international development assistance, the issue is often pre-selected by donors or other external organizations with little or no consultation with the community. The typical user of this field guide is likely to be in the position of implementing a program around an issue chosen by someone else. Whether you choose your own



**A well-defined focus on the main goal of the effort is critical at this stage and throughout the community mobilization process.**

health issue or have it handed to you, you will almost always be in a position to shape and define the issue with respect to the local circumstances in which you will be working. In that context, there are a number of things to keep in mind about choosing a health issue.

Defining the issue is an important part of selection. How the issue is defined will depend not only on the problem itself, but must also take into account how the issue is perceived by the community and externally. Program managers need to consider the political, cultural, and social context in which they intend to work to ensure that the definition of the issue is appropriate to the setting. For example, in some settings family planning programs and adolescent reproductive health programs may meet with resistance by politically powerful groups. Some of these programs have decided to broaden their definition of the issue to include a wider array of reproductive health issues or to integrate family planning into general family health services. Others may opt to address the issue head on and plan their approach accordingly.

Another thing to consider is whether the health problem is a symptom of a much deeper issue and whether you choose to mobilize around the symptom or the underlying themes. For example, women's health problems may be a reflection of women's low status in the community. Will you mobilize communities around women dying or the value of women? There are ways to build both into a program design, but you must first articulate the issue.

Finally, you may want to consider whether defining an issue too broadly would overwhelm community members to the point where they start to feel they could not possibly achieve related goals and therefore decide not to participate. A well-defined focus on the main goal of the effort is critical at this stage and throughout the community mobilization process. In general, if you have limited time and resources, community mobilization is more effective when the issue is more narrowly focused. A narrow focus, however, does not mean that community-generated strategies and activities to address this issue will necessarily be limited.







## Defining and selecting a community

As you select a health issue, you will also need to define the community or communities with which you will work. Community mobilization refers to “community” in its broadest sense. In the changing context of migration, urbanization, and globalization, the concept of “community” has evolved significantly beyond just a group of people who live in a defined territory. Today, community also refers to groups of people who may be physically separated but who are connected by other common characteristics, such as profession, interests, age, ethnic origin, a shared health concern, or language. Thus, you may have a teachers’ community, a women’s community, or a merchants’ community; you may have a community of people living with HIV/AIDS (PLWHA), displaced refugees, teenage boys, or men with STIs.

You may be in a position to have to choose from among a number of communities, in which case you will need to establish criteria. Your first inclination might naturally be to choose communities that have the poorest health indicators, but it is important to remember that trying new approaches also means making mistakes and learning from them. It is easier to do this with more forgiving communities that have a history of success and can help analyze what went wrong.

In selecting the community, you should also consider issues such as whether there is strong or weak identification among members of the community, and how and whether minority voices will be heard, particularly when people who are directly affected or are at higher risk of being affected by the health need that your program intends to address are marginalized from others in the community and have limited access to information and services. For true participation of minority or marginalized groups in the broader community (rather than tokenism), research indicates that these minority groups need to

### SOUTH AFRICA & RWANDA *Defining Community*

The AIDSCAP Project defined community in a number of different ways in order to focus on groups who were particularly at high risk for STD/HIV/AIDS infection. In South Africa, sex workers and their clients represented a particular social network or ‘community’ at high risk. Although geographically dispersed (e.g., representing truckers and migratory labor groups), this community was approached by the project to find solutions to the dangerously high rates of sexually transmitted diseases and infections. Community mobilization efforts focused on places where members of this particular social network would gather, such as brothels and bars.

In war-torn Rwanda, a psychosocial assistance program worked to help rebuild social networks together with widows, widowers, and children to develop a ‘community’ of caregivers to address children’s and care-takers’ psychosocial needs. During the first phase of the program, staff and program participants identified a ‘community’ of 12,000 separated and orphaned children in 70 residential care centers. The program worked with these centers to restore some sense of normalcy to children’s lives through recreational activities, training for caregivers on child development, and the Convention on the Rights of the Child, including the importance of play and protection. The second phase of the program moved away from these centers and worked with geographically determined ‘community’ villages. The program team worked to build the capacity of these communities to monitor and support separated and orphaned children. Community associations were developed and members received training and technical assistance to respond to the psychosocial needs of children and foster families.

*Save the Children Federation (US), Rwanda field office*



## VIETNAM: The Poorest of the Poor?

The Poverty Alleviation and Nutrition Program (PANP) in the coastal and lowland delta areas of Thanh Hoa Province, Vietnam was initiated in 1990 as part of a larger effort by seven international nongovernmental organizations (NGOs) in response to national political concern for childhood nutrition. The Government offered the PANP program team the choice of working in a province either in the north or in the south of the country. Thanh Hoa, in the north, was one of the country's poorest provinces, had a population of approximately 3 million and had no other international NGO's working there at the time. The magnitude of the problem of poverty, the potential for reaching greater impact through a large population base, responsive community leadership, and logistical proximity to Hanoi, where the field director was required to live, were all contributing factors to deciding where the project would operate.

The Thanh Hoa Provincial chairman of the People's Committee decided that PANP would be initiated in the Quang Xuong District. The chairman chose the most populated district (250,000 inhabitants) with the highest levels of malnutrition. For the initial pilot phase, the program team deliberately selected four of the poorest communes within Quang Xuong District totaling a population of 26,057. This choice of the "poorest of the poor" was based not only on traditional criteria for targeting the beneficiaries of its services, but also on the belief that any model program that would emerge from these conditions would stand the best chance of being sustainable and replicable throughout the country.

*Save the Children Federation (US), Vietnam field office*

have at least a 35 percent representation to have their voices heard as a group. When a minority's representation reaches at least 35 percent, it has a much greater chance of forming alliances with others that result in changes in the overall group culture. At a 40-60 split, the group begins to become more balanced and individual voices can be heard (Kanter, 1977).

At this point in the selection process, you will need to make a formal, conscious decision about mobilization. You will, in effect, be trying to answer the question: Does mobilization promise to be an effective approach to address this particular issue in this particular community at this particular time? Consider the following factors in light of whether in your situation they may *facilitate* or *inhibit* a successful community mobilization effort:

- **Magnitude of the problem:** an objective measure of prevalence or extent of the problem.
- **Political support:** local, regional, national and/or international policies, political will (including commitment to allocate resources) in place to support community efforts on the issue.
- **Sociocultural context:** values, beliefs, attitudes, and practices related to the health issue and participation in collective action that may facilitate or inhibit participation in this collective effort. For example, a community that is resistant to change and is suspicious of outsiders will be more challenging to work with than one that is motivated to change and values external perspectives and experience.
- **Resources:** time, money, skills of staff and community, communication channels, equipment and supplies.



Prepare to Mobilize



- **Organization:** includes presence of organizations or agencies involved in the issue, the presence of traditional systems for dealing with the issue, and the amount of effort and resources expended on the issue in a defined period of time by any sources within the community. You should also consider personal networks—the patterns and dynamics of interpersonal relationships in the community can be powerful facilitators or constraints. How much routine interaction exists among members of the community (in general and/or with respect to a given issue)? How extensive and interconnected are the networks? How many people have personal networks that extend beyond the boundaries of the community (these can be important sources of inspiration and resources)? How does information about social issues in general or about a particular issue flow through the community? Is the flow egalitarian or top down? Are there recognized leaders around which collective action can coalesce? How are these leaders' roles perceived by others in and outside the community?
- **Feasibility of response:** the extent to which communities can take action to address the health issue. For example, community mobilization around a health issue will be easier if proven technical interventions are available and acceptable to community members as opposed to a situation in which these interventions are not available, may be too expensive, or are not culturally or otherwise acceptable to community members.
- **History of community participation:** extent to which collective action—in general and/or specific to the issue—has previously occurred in the community.
- **Accessibility:** geography, climate, availability/use of transportation, and so forth.
- **Representativeness of other areas in the country:** language, ethnicity, and so on.

**You should also consider how personal networks—the patterns and dynamics of interpersonal relationships—in the community can be powerful facilitators or constraints.**

You should also consider how community individuals and organizations perceive these factors. Their perspectives will positively or negatively affect whether they choose to participate in the effort.



You may find the “Factors to Consider in Community Mobilization” matrix (Useful Tool I at the end of this chapter) a helpful way of organizing your deliberations at this point. Even if the decision to mobilize communities has already been made for you, you may still find it helpful to think about the various facilitating and inhibiting factors presented in this matrix. As you think about your decision, remember that the fact that a community is characterized by many inhibiting conditions does not necessarily mean that you should give up the idea of working there. But these factors will certainly affect your mobilization design.

## STEP 2: Put together a community mobilization team.

Preparing to mobilize should not be the work of one person. Before you get very far into this initial preparation stage, you will need to put together the team of people who will be working with you to support the community on this project. You may want to do this before you set about defining the health issue. This team may be made up exclusively of people from your own organization, or it may include members from partner or other organizations. Throughout this field guide, we refer to this team as the “community mobilization program team” or “program team” for short.

How do you decide who should be on the program team? In the end, it may all come down to practical considerations, such as who has the time or interest, or to considerations beyond your control, such as the preferences of donors or other outside organizations. If you have the opportunity to choose some or all of your own team members, you should consider the following criteria:



- Expertise in the health issue.
- Understanding of the political, socio-cultural and economic context (knowledge of the community and macro environment).
- Basic community mobilization skills: communication and facilitation skills, program design and management skills, organizational behavior/group dynamics skills, capacity-building skills, planning and evaluation skills, knowledge of participatory methods.
- Personal attributes, such as openness, flexibility, patience, good listening skills, diplomacy, and most importantly, belief in people's potential.

As you get further into this preparation stage, you may see the need for other team members and want to add to your original team. Moreover, team composition may change as you move through the various stages of community mobilization, with different skills needed at different times. But even from the beginning, the wider the variety of perspectives represented on your team, the less likely you will overlook important issues. We discuss developing your program team in more detail in Step 6.

### STEP 3: Gather information about the health issue and the community.

After you have defined the health issue and put together your team, it will be time to explore the issue in greater detail and learn as much as you can about the people who are most affected by it and the community you are planning to work with. This knowledge will be essential when you come to the next to last step of this preparation phase: designing the overall goals and objectives of your community mobilization plan. But you will also need this information when it comes time to develop your team, for example, to decide if you need a partner (and how to choose one), and to identify your resources and constraints. These actions cannot be carried out until you are familiar with the health issue and the community.

#### Are You Ready to Commit to Community Mobilization?



If you and your team answer *yes* to the following questions, then this approach is right for you.

#### Are you really prepared to:

- Advocate for project flexibility in front of donors and partners (with regard to: time, specific objectives, indicators, and methods)?
- Value and respect local knowledge and capacity?
- Let things fall apart and watch communities “learn by doing”?
- Test your own assumptions and beliefs and admit that some are wrong?
- Lose control and share power?
- Have fun and grow from experiential learning?
- Act as a liaison between the community and others at times?
- Be a facilitator and not a teacher?
- Listen—“seek first to understand and then to be understood”?
- “Think big, start small”?
- Work to build the community?

## Gathering information about the health issue

The following questions will help you in gathering information about the health issue.



- Who is most affected by the health issue?
- How many people are directly affected? Indirectly? This number needs to be determined in the context of how you are defining the extent of coverage of your effort: one community? several communities? a district? a region of the country?
- Where do the most-affected people live? Do people who are most affected by the issue live close together? Are they near to a source of the problem (e.g., contaminated water source)? Are health and other services available near where they live? Are they difficult to locate because they are not within a specific geographic area but form a community based on other characteristics?
- What are their socio-demographic characteristics? Do people who are most affected by the issue share similar characteristics (age, sex, income levels, ethnic groups, language, and other factors)?
- Why are these people most affected? Your team may want to explore aspects of the health condition itself that make some people more likely to be affected by it (risk factors and/or specific practices). Do they have limited access to information, services, and resources due to discrimination, geographic/social/cultural isolation, and many other factors? To what extent do they decide what they do, or do others decide for them? Who influences their decisions and practices at the household level?
- What are current beliefs and practices related to the issue? Who decides and/or influences what will be done and how at the community level? How do you know this information? What don't you know?
- Are the people in the community organized around this or any other issue? How? Is there any history of mobilization in the past?
- What is the level of capacity/skills (any participation in/experience with collective assessment, planning, action, monitoring/evaluation, decision-making, negotiation)?

- How do those most affected by the issue interact with the rest of the community? With decision-makers? Do they have access to resources? How have they managed resources in the past?

When in doubt, it is always preferable to admit to not knowing. In fact, it is better to be humble and open to exploring multiple perspectives. Communities are not homogeneous, and knowledge and practices vary among members. This type of information can be obtained through surveys, anthropological studies, participatory research, and other means. Each method has its strengths and weaknesses, and you should be aware of these as you gather information. If you can find little existing information, you will need to develop a more comprehensive process to explore this area.

### Gathering information about the community

The following is a list of topics and questions you may want to use to gather information about the community.

- **Sociocultural context**  
How is the community organized? (Social class, ethnic groups, languages spoken [dominant language, others], religions, age)  
What are the traditional groups and organizations? What are their roles and functions? Who belongs to them? How do they relate to each other?  
Who is wealthy? Who is poor? How do you know?  
How is land allocated?  
How do people support themselves and their families?
- **Gender relations/roles**  
What traditionally are men's/boy's and women's/girl's roles?  
What proportion of men are directly affected by the issue? Women?  
Who has access to what (e.g., information, services, resources)?  
What are the power relations between sexes?
- **Politics, leaders, and organizations**  
What is the traditional organizational structure of the community? Who



**When in doubt, it is always preferable to admit to not knowing. In fact, it is better to be humble and open to exploring multiple perspectives.**



leads? Which groups participate in decision-making?  
Who are the official community leaders?  
Who are the informal/traditional leaders?  
How are community decisions made? Who participates?  
How is official leadership transferred?  
What links does the community have to external political systems outside of the community (e.g., representation in a municipal, district, or regional body)?  
Is the community considered to be a “priority” area by government officials? Is there a strong constituency or is the community relatively abandoned with little political capital?  
Which groups and leaders are strongest and/or have the greatest support of the broader community? Of external organizations?

- **Economy**

What is the current economic situation in the country, region, and community (e.g., high inflation, high unemployment, heavy loan debt)?  
What is the average income of the families in the community?  
How do most families support themselves?  
What percent of families are considered poor?  
What is the level of external assistance?

- **History**

When was the community established? By whom? Why?  
What is the history of collective action by the community?  
Has the community ever worked collectively on health issues before?  
Which issues? What were the results?

- **Geography**

Where is the community located (e.g., geographically limited or dispersed)?  
Which characteristics related to the community’s location will likely affect implementation of a community mobilization effort (weather/seasons, mountainous, dispersed population, highly populated urban neighborhoods, easy to reach or hard to get to, and other factors)?

- **Epidemiology and health systems**

What is the frequency of the health problem in identified groups (e.g., community-wide, specific groups within a community)?



Which factors related to the health issue are important to consider (e.g., how disease is spread; risk factors; protective factors)?  
 How is the public health system organized?  
 How does health care financing work in this setting?  
 What role does traditional medicine play?  
 What is the coverage and utilization of public/private/traditional health services?  
 What are the most significant challenges faced by the health system/ services?  
 What are the strengths and weaknesses of the health services/system?  
 How good is the quality of care? From whose perspective (community members, providers, external observers)?

## Sources of information

As a practical matter, there are two general sources from which you can obtain information about the health issue and the community: documents of one sort or another and interviews with informants, such as community members and leaders, NGO staff, government officials, health workers, and anyone else familiar with the issue or the community.

Examples of the first source, documents, typically include the following:

- General resources (books, maps, reports) about the political, economic, and social characteristics of the country, region and area in which you are planning to work. Bookstores, university libraries, and some Ministries sell these items; organizations working in the area may have them; also check with donors and government agencies.
- Health and other statistics from Demographic and Health Surveys,<sup>2</sup> national statistics, studies and surveys, PVO/NGO data and reports, facility-based service and coverage data.

<sup>2</sup> For more information, contact Measure DHS+, MACRO, Macro International Inc., 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, USA; Tel: (301) 572-0456; Facsimile: (301) 572-0999, Web site: [www.measuredhs.org](http://www.measuredhs.org); Email: [MEASURE@macroint.com](mailto:MEASURE@macroint.com).



**The formal district/municipal and community health services are a good place to start to gather service statistics, coverage rates, mortality data, and other information.**

- Qualitative and quantitative research studies related to the issue, such as those often done by technical assistance agencies, donors, NGOs, and universities.
- Policy statements from ministries and facilities.

The formal district/municipal and community health services are a good place to start to gather service statistics, coverage rates, mortality data (if available), and other information. But don't stop there because service statistics may be unreliable and often provide only a part of the complete picture, particularly when service utilization is low. Check with private and nongovernmental organizations that work in the community or have worked there in the past. Review comparative data from studies such as the Demographic and Health Survey (if available), epidemiological and anthropological studies, knowledge/attitudes/practices/behavior studies, and other related studies done by universities or international organizations.

You may decide that you need to carry out some kind of survey to find out more about the community. While you should probably guard against doing anything too elaborate or daunting at this preliminary stage of information gathering, there are a number of survey tools you can turn to if you need such an instrument, including the Situation Analysis,<sup>3</sup> Health Facility Assessment Tool,<sup>4</sup> cluster surveys, and household surveys. For more information about these tools, see the resource guide at the end of this chapter.

<sup>3</sup>For more information, contact The Population Council, One Dag Hammarskjold Plaza, New York, NY 10017, USA; Telephone: (212) 339-0500; Facsimile: (212) 755-6052; Website: [www.popcouncil.org](http://www.popcouncil.org); E-mail: [pubinfo@popcouncil.org](mailto:pubinfo@popcouncil.org).

<sup>4</sup>For more information, contact BASICS II, Basics II Headquarters, 1600 Wilson Boulevard, Suite 300, Arlington, VA 22209, USA, Telephone: (703) 312-6800, Facsimile: (703) 312-6900; Website: [www.basics.org](http://www.basics.org); E-mail: [infoctr@basics.org](mailto:infoctr@basics.org).





## Initiating contact with the community

In most cases you will want to supplement what you can learn about the community from documents with interviews with various informants. (See Useful Tool II at the end of this chapter for a sample interview questionnaire.) It is at this stage, if not sooner, that you will begin to have significant contact with the community, and you and your team may want to give some thought to how you can make a good first impression.



First impressions are based on a whole set of cultural values, personal beliefs, and prior experiences. While our first impressions may be proven right or wrong later, they have a lot to do with whether and how relationships begin. A bad first impression is difficult to overcome. All this is to say that it is important to consider the type of impression that you would like to create when you enter a community. What you wear, how you act, which language you speak, what you say and how you say it, even how you arrive—in a car, which almost no one in the community owns, or on public transportation which almost everyone uses—all these things will be noticed and discussed by community members when you leave.

If you are not familiar with local community protocol, it is important to learn about it early on. You can talk with people who are working in the community or who know about local protocol to find out which people you will need to contact first and what will be expected of you during the first visit.

Some things to consider when entering the community:

- Know local customs and protocols for meeting leaders and others, and follow them.
- Ensure that someone on the team speaks the local language and dialect.
- Prepare materials before the visit (a short description of the project/program, information on your organization, questionnaires, or interview guides).
- Be honest and don't promise things that you can't deliver.
- Be respectful of people's time and schedules.
- Decide what type of first impression you want to create.





## VIETNAM: Asking Why

During group discussions arranged by commune leaders early in the program, a program manager asked villagers to make a list of their problems and ended up with a shopping list of requests: “we need water pumps”; “a new school building”; “what really would help us is electricity, improved roads, and a bridge”; and “seeds and tools.” Program managers took the opportunity of their request for seeds and tools to ask them ‘why’ this particular intervention was important to them. The response initially was “because this will increase our agricultural production”. Again, the question ‘why,’ was asked of community members, and the response was, “so that we will have more seeds to plant for next season.” With continual probing using the question ‘why,’ eventually program managers were able to get to the bottom of why food was important – the response was eventually stated “in order to keep our families and children healthy.” The important topic of malnutrition was then raised with communities, and a decision was reached that by working together this problem could be addressed if community members were interested.

*Save the Children Federation (US), Vietnam field office*

When community mobilization is initiated by an external organization, the objectives of the first meeting with community leaders are usually to determine whether the community is interested in participating in the project, to begin to establish a working relationship, and to set a tone for the project. You may also want to discuss how you propose to learn more about the community to help the team determine how best to work with the community. Your team should be prepared to clearly present the project goal and how it was determined. It is often helpful at this point to share national or regional data with leaders to show why this particular health focus was selected and to put the community’s health into a broader context. You should also be able to explain your organizational capabilities and your team’s role in this project.

### What does my information *mean*? Looking for underlying themes.

After you have gathered information about the people with whom you will be working and the conditions under which they live, it is important to analyze this information for evidence of underlying themes which may affect the impact of the health program—to look for the *meaning* behind the data you have so painstakingly gathered.

This process is necessary to ensure that the approach you and your team develop addresses some or all of the major underlying causes of the health issue. For example, much of the data you collect will necessarily be in the form of symptoms, but in designing your mobilization effort you will want to be sure to address the themes or causes behind the symptoms. Many community mobilizers working in the field do this intuitively and there is relatively little documentation on how they do it.

There are several tools and techniques that can assist you as you look at underlying themes. As is the case with all tools, some work better than others in certain cultural settings. One simple method to use with your team to analyze your data is to repeatedly ask “Why?” until you get to some of the real underlying issues. For





example, you could pose the question: “Why are maternal mortality ratios higher in communities in the south region of the country than in the north?” to your team and ask each member to write down his/her response. Then ask them to consider their responses and again ask why and write down another response, and so on until you have done this four or five times. All members of the team can then share their responses with the group and discuss what they are learning.

There are no magic formulas to apply during this analysis of underlying themes, and you may miss important ones. In the spirit of “learning by doing,” your team’s first analysis of key themes serves as a point of departure, but you should revisit these factors and adjust your approach as you learn more about the community.

### Positive deviance

In exploring the health issue it can also be very helpful to identify and study the people who *should* be affected by the issue but apparently are *not*; that is, people living in the same area and/or under the same conditions who have the same risk of being affected by the issue but who are healthy and doing well in spite of the presence of risk factors (such as the “positive deviants” in the Vietnam case study in the box). In other words, you should not confine your information gathering to learning only about what doesn’t work in the community but also about what does. For more information about research tools and techniques for gathering information, see Useful Tool III at the end of this chapter.



### VIETNAM: Positive Deviance

The foundation of the Poverty Alleviation and Nutrition Program in Vietnam (PANP) is a “strength-based” approach focusing on respect, recognition, and application of positive local knowledge and practice. The PANP program targeted so-called ‘positive deviants’, in this particular case it was poor families who somehow managed to keep their children well-nourished, and tried to learn from their positive example. Such an approach asks how poor families can have well nourished children when their neighbors, with access to the same resources, do not? In other words, what is their “deviant behavior?” The process galvanizes households at risk in poor communities to quickly identify and adopt affordable, lasting solutions to vexing problems from their own impoverished neighbors’ experience.

Despite the high prevalence of malnutrition in the Thanh Hoa province, Save the Children observed that a narrow majority (55%) of children were actually normally nourished according to UNICEF’s criterion, and further observed that some of these children were from very poor families. Visiting some of these poor families with adequately nourished children, volunteers observed what went into the cooking pot and the kind of child care the family provided. The ‘deviant behavior’ turned out to be the use of tiny shrimps and crabs, easily found in rice paddies (but initially considered inappropriate for young children), sweet potato greens, sesame seeds, peanuts, dried fish, fish sauce, and corn. The food varied by community and season but was free or inexpensive.

The positive deviance inquiry is well suited to communities where a problem is common, recognized, important, demonstrable, and remediable through behavior already modeled by some individuals within the community. The approach is based on the belief that in order for development gains to be sustainable, strategies and solutions to community problems had to be identified within the community by the members themselves. Translating this idea into action helped PANP to focus on community resources, as well as needs, essential for both sustainability and scaling-up. The focus is on the discovery of community resources, both human and material. This process contrasts with the more traditional development approach that focuses on community needs as the principal basis for program development while not fully recognizing existing community resources and strengths.

*Save the Children Federation (US), Vietnam field office*

**Identify what constraints you may face in carrying out the effort and ways to eliminate, minimize, or work around these constraints. In many cases, constraints will be directly related to resources.**

## STEP 4: Identify resources and constraints.

Now that you know more about the health issue and the community, you will need to do an inventory of the resources that will be available to the program and any constraints you may face. You and your team should complete a simple worksheet where you list resources according to the following categories:

- Financial resources: project budget, income from all sources, including municipal government, the private sector, Ministry of Health funds, and nonprofit organizations.
- Human resources and the types of skills they can contribute: skilled project staff, collaborating organizations' staff/members, community members willing to work on the project, and others.
- Material resources: meeting space, supplies, meals, computers, vehicles, other equipment, office space.
- Time.

After you identify resources, you should then identify what constraints you may face in carrying out the effort and ways to eliminate, minimize, or work around these constraints. In many cases, of course, constraints will be directly related to resources. For example, constraints might be that project staff do not possess the skills to do the work, that there is insufficient time to achieve the desired results through a high quality program, or that there are very limited financial or material resources.

Constraints may also arise from seasonal, geographic, political, or logistical difficulties. For example, the communities with which you propose to work are located in a region that is only accessible during six months of the year because floods knock out the bridge during the rainy season. Planting and harvesting may rule out work with some communities during three or four months as community members are too busy to attend meetings and engage in other activities. And you may also run into political constraints, cultural constraints, or language-related constraints. Try to anticipate as many of these as you can.



After you have identified the resources you will need and the constraints you face, you should decide where you will get the former and how you will address the latter. In making these decisions, you will in some cases have to change or even eliminate certain activities that are simply not feasible given your situation. Alternatively, some programs may face the challenge of managing excessive budgets which can create great pressure on program managers to expend them, regardless of potential consequences such as unsustainable incentives, inflated community and health service provider expectations, distortion of the local economy, and other similar problems. You should not hesitate to adapt your plan in light of a realistic assessment of your circumstances. It's much better to make these changes now, in the early stages of your preparation, than after you have launched the mobilization effort and raised expectations.

## STEP 5: Develop a community mobilization plan.

Now that you and your team have a better understanding of the health issue you will be working on, the setting you will be working in, and your resources and constraints, it's time to develop a community mobilization plan. (If you have limited prior experience with community mobilization, you may want to read the rest of the field guide before developing your plan.) This plan is a general description of how you and your team intend to assist this particular community to mobilize around this particular issue. For those teams working with a donor, this plan may serve as the project proposal or the basis for it if the donor requires a different format.

The purpose of the mobilization plan you are developing is to define the overall program goals and objectives and identify a process that will help interested communities achieve them, not to determine specific community actions or activities. As you create this plan, you should always keep the two overriding goals of community mobilization uppermost in your mind:

**The purpose of the mobilization plan you are developing is to define the overall program goals and objectives, not to determine specific community actions or activities.**

1. to improve the health of the community, particularly those people most affected by the issue
2. to improve the community's capacity to address its health and other needs



At a minimum, a typical community mobilization plan should contain the following seven elements, each of which is described in detail below. A sample mobilization plan, for the Bridges (*Puentes*) program in Peru, appears as Useful Tool IV at the end of this chapter.

1. background information
2. program goal: the overall goal of the mobilization effort
3. program objectives: the overall objectives of the effort
4. the community mobilization process: the overall process you and the community will go through to achieve the goal and objectives
5. a monitoring and evaluation plan
6. a project management plan
7. a budget

### **1. Background information**

This section should describe the overall context for the plan, including information about the health issue, the setting, the resources and constraints, and why this particular community was selected.

### **2. Program goal**

In some cases, the goal of the program has been predetermined in relation to global, national, or local health priorities as identified by the donor. In other situations where communities perceive a pressing need, communities themselves may define the goal. Alternatively, public health officials or others may identify a goal based on an analysis of community health indicators (e.g., frequency and severity of specific health problems and feasibility to address them).



Prepare to Mobilize



No matter who defines it, a clearly articulated goal that can motivate the community is one of the most important keys to an effective community mobilization strategy. This does not mean that you should ignore what donors, public health officials, or program staff want to achieve but to state the goal in concrete, personal terms that people will understand and want to support.

Community mobilization goals sometimes mistakenly aim at promoting behaviors, such as “mobilizing people to vaccinate their children,” rather than emphasizing the potential benefits, such as “reducing the number of children who get sick or die from diseases that can be prevented by vaccination.” The *Warmi* project goal, for example, was to reduce maternal and newborn deaths, while in Vietnam the project goal was to restore malnourished children to good nutritional status.

### 3. Program objectives

There are many resources on how to define objectives in the context of program design. Many discuss the characteristics of well-defined, “SMART” objectives—specific, measurable, attainable, result-oriented and time-limited—and these are valid and useful. When mobilizing communities, however, our role is not to define the specific objectives of the overall effort because the primary actors, the community members, will do this. Instead, the plan’s objectives will focus on general health outcomes and process objectives related to building community capacity and to the key underlying themes that we identified while learning about the community. Our aim at this point is to set a direction for the process so that facilitators can judge whether the program design is effective or whether it needs to be adjusted. For those familiar with project design, this approach to setting objectives is different because it takes the setting of specific objectives out of their hands and puts it into the hands of community members.

Those who work with donors may need to explain why it is so important for community members to define and commit to their own objectives. For example, when negotiating the approval of the *Warmi* project design, donors, other program staff and the project designers discussed at length why the project did not

**A clearly articulated goal that can motivate the community is one of the most important keys to an effective community mobilization strategy.**



**Those who work with donors may need to explain why it is so important for community members to define and commit to their own objectives.**

propose specific objectives with clearly identified indicators, as is expected with most proposals. Instead, the *Warmi* project proposal stated that the list of objectives and indicators presented in the proposal was illustrative and would be revised based on work with communities to set priorities and appropriate objectives. Fortunately, the donor was flexible and understood the rationale behind the proposal, and the project was approved with the agreement that once objectives were defined, they would be communicated to the donor.

Here are two examples of objectives, from the SECI project in Bolivia and the Bridges project in Peru. The SECI project aimed to:

1. Increase communication between participating communities and health service providers through the use of a community and facility-based health information system to contribute to improved health.
2. Increase participating communities' and health service providers' ability to analyze and use information to address community health problems.

The Bridges project had the following objectives:

1. Increase the utilization of public health services in selected project areas.
2. Improve client and service provider interpersonal interactions within health services.
3. Establish mechanisms and/or systems to improve coordination and collaboration between health services and community organizations.

The Bridges Project went on to articulate general process objectives based on the key underlying themes identified through analysis of information gathered while learning about the community. These process objectives, stated as "desired results," follow on the next page.



## EXAMPLE of Underlying Themes and Desired Results from the "Bridges" Project in Peru



UNDERLYING THEMES	DESIRED RESULTS
<ul style="list-style-type: none"> <li>• Power</li> <li>• Respect</li> <li>• Self-esteem</li>   <li>• Gender</li> <li>• Quality (central theme around which to mobilize)</li>   <li>• Rights and responsibilities</li> <li>• Differing paradigms/belief systems (western medicine vs. indigenous knowledge)</li> <li>• Team work</li> <li>• Critical self-reflection and objectivity</li>   <li>• Protagonism</li> </ul>	<ul style="list-style-type: none"> <li>• Create a more equitable balance of power between communities and service providers</li> <li>• Develop mutual respect</li> <li>• Build self-esteem (of both community members and service providers)</li> <li>• Ensure that women are active participants in the process</li> <li>• Shift concept of quality from service-based to "quality begins at home"...services are only one component of quality care</li> <li>• Shared responsibility for health</li> <li>• Acceptance of differing perspectives; dialogue to maximize benefits of positive, healthy beliefs and practices regardless of origin</li> <li>• Encourage development of a team</li> <li>• Foster environment that promotes critical self-reflection and objectivity</li> <li>• Foster protagonism (communities and providers set agenda, implement, monitor, and evaluate their progress)</li> </ul>

### 4. The community mobilization process: the Community Action Cycle

This field guide recommends structuring community mobilization efforts around the five phases of the Community Action Cycle, and adds two other phases: pre-prepare to mobilize and scale up. Accordingly, as you and your team sit down to develop your mobilization plan, you can assume that in general this cycle is what you and the community will be going through as you carry out this effort.

Using the Community Action Cycle as a guide and keeping in mind the overall approach you wish to take and the strategies you outlined above, describe the basic tasks/activities you propose for each phase of the process. This plan does not need to be very detailed at this point, but for planning and budgeting purposes you should consider the types of activities, who will participate (approximate numbers and characteristics), and what you hope to achieve through these activities.

**The monitoring and evaluation section of the proposal should state, at a minimum, which health related outcomes will be monitored on an ongoing or periodic basis and how.**

In the Bridges example presented at the end of this chapter, the team proposed using participatory video as a medium to facilitate self-reflection in the exploration phase. This video served to communicate both parties' opinions to each other without having to confront each other directly in a potentially explosive manner, but also without "dehumanizing" the content which could have resulted had they presented it through second parties or on audio cassette. This activity supported the project strategy of getting to know each other to begin to develop a relationship that went beyond current poor provider-client relations, while it also dealt with exploring the content of the health issue: what is quality care?

### **5. Monitoring and evaluation plan**

Community participants will have the opportunity to develop their own monitoring and evaluation plan as part of the community action cycle process. However, the project monitoring and evaluation plan should meet your team's and your donor's needs for information. This section of the proposal should state, at a minimum, which health related outcomes will be monitored on an ongoing or periodic basis to determine if the objectives are being achieved. Additionally, you should consider which areas of community capacity or other process outcomes you will monitor, how and when. At this point, it may be premature to specify community capacity indicators until you have worked with the community to determine which areas they would like to strengthen. However, you may want to state how you plan to work with the community to come to this agreement. We recommend that you use both qualitative and quantitative measures and a combination of participatory and external methods, if possible, to provide a more comprehensive picture. If you do not have the resources to afford this, you should discuss which methods you have chosen and why in relation to the overall goals of the project and in light of various stakeholder interests.



## 6. Project management plan

This section of your plan should state who the members of the program team are, how they will communicate and work together, what their roles will be in relation to the project participants, and describe coordination mechanisms and institutional relationships if appropriate.

Staffing will vary according to your available resources (time and money), the number of communities and population you are trying to reach, and your project strategies and activities. Experience demonstrates that it is reasonable to estimate that a team of two people can work with between ten and twenty communities, even in settings that are geographically dispersed. Teams are recommended, as one person can facilitate while the other assists, observes, and documents the sessions. One person can facilitate sessions alone, but it is more difficult and is not recommended if two can possibly work together. If community capacity is such that a local person can facilitate, and having local facilitators is desirable, you may be able to have one person from your team support the effort by helping to prepare the facilitator, observe, document, and provide feedback to him/her.

## 7. Budget

Most proposals will also include a budget based on the management structure and activities proposed. It is not within the scope of this field guide to go into detail here on how to budget. However, as with all budgeting, you should consider the costs of personnel, equipment, materials and supplies, travel and transport, other direct costs for training, administration, and other project activities not previously covered.

## STEP 6: Develop your team.

Once you have drawn up your mobilization plan, it will be time to develop your team. One of the first steps in this process will be to define the role your team is going to play in implementing the mobilization plan. Outside organizations can play a variety of different roles as mobilizers, depending on the nature of the effort and the needs of the community. Some of the more common roles include:

**Mobilizer or catalizer:** Works directly with existing leaders and community groups to stimulate action.

**Organizer:** Forms new organizations or brings existing organizations together in new ways around an issue.

**Capacity-builder/trainer:** Helps to build capacity to achieve CM goals.

**Partner:** Complements local organizations in a joint effort.

**Liaison:** Links communities with resources and partners, builds networks.

**Advisor:** Provides assistance to communities who request specific advice/technical expertise.

**Advocate:** Supports community efforts to obtain resources or change policies.

**Direct service provider:** Provides a service (e.g., health care, education).

**Donor:** Provides funding to the community to address health issue.

**Marketer:** Shares experience with others to expand CM.





Your team's role may change over time as both your own organization's needs and the community's needs and abilities change and as other circumstances change. It is a good idea to think through your short-term roles and plan for your long-term roles so that you may lay the groundwork more proactively. For example, if you begin work with a community as an organizer, you may want to gradually move toward being a partner and then a liaison or advisor as the community organizations' capacity is strengthened. You should continually reassess your team's role(s) and be flexible enough to respond to new community needs as the community mobilization process unfolds. As important as defining what your role is, it is equally as important to define what it is not. Team members who understand and can present clearly what their role is and is not are better able to avoid future misunderstanding and confusion.

One of the last things you and your team will do in this preparation phase is to look again at the tasks you've set for yourselves and decide who is going to be responsible for what. Once you have done this, it will become clear as to whether your team members have the skills they need for the duties they've been assigned. If they don't, you have several choices:

- You can add people to your team who do have the needed skills.
- You can train people in the needed skills.
- You can partner with another organization who has people with the needed skills.

The size of the team is also an important question. If your team is going to be directly involved in facilitating the community mobilization effort, the ideal size is two people for every eight to ten communities. If your team is going to play a less central role, you can have fewer members.

## BOLIVIA: Facilitators, Not Educators

In keeping with a participatory approach, program managers realized that critical to the success of *Warmi's* community mobilization methodology in Bolivia would be viewing the role of project staff as mobilizers or facilitators rather than educators. Taking the approach that the only lasting form of development is one where the participants take control of their situation and make collective decisions on improving it, project staff were then able to assume the role of assistants in this process, facilitating and aiding participants in making their decisions and in converting them into action.

This underlying project philosophy relating to staff roles was of central importance. The approach encouraged staff to continuously assess the learning taking place in the areas of knowledge, attitudes, and practices both of participants and of staff. The approach taken with project staff was one of learning through actually doing. Initially, many staff members were inhibited in their work, believing that they should have answers for every question (which, of course, they didn't). The project fostered the idea that there is no one correct answer to any question nor is there any one solution to a given problem. It is only through a process of collective decision-making and action that an issue affecting a community can be addressed.

*Warmi's* program managers recognized that before staff could begin to work with the Inquisivi community, they needed particular skills to prepare them for their role as facilitators and as effective actors in the community mobilization process. Accordingly, *Warmi* program managers built sufficient time for staff training into the initial stages of the project.

*Save the Children Federation (US), Bolivia Field Office*

However you decide the question of team size and composition, you want to approach the next stage in the community mobilization process—organize the community for action— confident in team members’ ability to do the work you’re about to embark on.



At this point it may also be helpful/necessary to spend some time on basic team-building activities. (See Useful Tool V and references in the Resources Guide under “Nonformal participatory learning” at the end of this chapter.)

Finally, it may help the team and the team manager to discuss and agree on the role the team manager will play in the CM effort. The team leader (usually the program manager) should consider the following in developing his/her team:

- Create a shared team purpose with a common vision, goals, and objectives.
- Establish and model values.
- Clarify roles and responsibilities of team members.
- Create a “learning” team (create an organizational culture to stimulate self- and group assessment of individual and team strengths and weaknesses in critical areas such as facilitation, communication, participatory methods and approaches, nonformal education, community organizing).
- Work to prevent and/or resolve conflicts among team members.
- Encourage and reward creativity and innovation.
- Problem-solve, troubleshoot.
- Build consensus around strategies and approaches.
- Serve as institutional representative liaising with donors, partners, communities.
- Celebrate successes!





# Useful Tools

## I. Factors to Consider in Community Mobilization: A Worksheet (Step 1, pages 10-12)

This worksheet will help you identify the pros and cons of mobilizing a given community around a particular issue.

FACTORS TO CONSIDER	CONDITIONS THAT FACILITATE CM	CONDITIONS THAT INHIBIT CM
Magnitude of the problem		
Political support		
Sociocultural context		
Resources (time, money, skills of staff and community, equipment and supplies)		
Organization		
Feasibility of response		
History of community participation		
Accessibility (geography, climate and so forth)		
Representativeness of other areas in the country		



## II. Questionnaire for Community Interviews

(Step 3, page 19)

This questionnaire can be used with community leaders and other key informants who are knowledgeable about the community. You may want to add basic questions about the interview (where and when it took place and which community is the subject of the interview), the interviewer (who conducted the interview), and interviewee (name, address, contact information, age, sex, and other information).



1. How many years have you lived in/been a part of this community?
2. What is your current role in the community?
3. What is the population of the community?
4. How is the community organized? What are the community-based organizations? How do they relate to each other?
5. Who are the formal and informal leaders? How are the leaders chosen?
6. What do you see as the most important priorities of this community?
7. What is the community doing to address these priority areas?
8. What do you think are your community's greatest strengths?
9. What are the greatest challenges you face as a leader in this community?
10. How are decisions made in the community about what the priorities are and how resources are allocated (e.g., budget, human resources)?



11. What are the major health problems in this community?
12. Have community groups or organizations here ever worked together on any health issues? Yes? No? If yes, which issues? Which groups? What did they do? What were the results of these efforts?
13. We are interested in working with interested communities on\_\_\_\_\_. Do you think that this community would be interested in exploring this issue with us? Why? Why not?
14. If we were to work with this community on this issue, with whom should we work? Which individuals and groups or organizations would be important to include in this effort?
15. How should we approach these individuals and groups? What do we need to do to begin to discuss this project with them?
16. What is important to know about this community as we begin to develop a community mobilization program?

### III. Research Tools and Techniques

(Step 3, pages 13-21)

The Resources listed at the end of this chapter provide more in-depth information about these tools and how to use them.

#### Information gathering tools:

1. Household census: provides information on total number in the population and demographic characteristics (age, sex, ethnicity, economic status, education status).

*Advantages:* gives most complete general population information and provides a denominator for calculations on coverage, prevalence, *et cetera*.

*Disadvantages:* expensive, takes time, may require computer hardware and software capable of handling large data sets.

2. Demographic and health surveys: an internationally used tool that targets representative areas of countries to survey sample groups on demographic characteristics, health status, practices, and knowledge.

*Advantages:* if done in your country, it is information already available that is relatively accurate. It may serve as a reference to compare local data to regional and national data.

*Disadvantages:* is not done at a community level and may not have been conducted in the part of the country in which you are working, so may not be representative of the population you are working with.

3. Knowledge, attitudes and behaviors/practices/coverage surveys: usually interview surveys carried out in a sample of households to determine current knowledge, attitudes, and practices related to a health topic.

*Advantages:* can provide team with information that can be used to help orient participatory research process by highlighting areas for further exploration or clarification. Can provide an idea of the magnitude of certain knowledge, attitudes, and practices.

*Disadvantages:* interviewees may respond with what they think interviewer wants to hear, especially when interviewers are unknown. Formats are often closed and don't easily accommodate explanation or answers outside of predetermined choices.

4. Health facility registers/patient records: provide information on use of health services and incidence of illness of those who use health services.

*Advantages:* if you have access to all service registers in an area and these registers are well-maintained, these records can be helpful to establish a baseline of utilization of health services that can be monitored over the life of the project.



*Disadvantages:* not very useful when health-related behaviors and practices are primarily home-based or when there are many possible providers and you only have access to information from a limited number. There are sometimes disincentives for health staff to keep accurate records. Need to ensure that registers are kept the same way throughout the project period. Statistics may be consolidated by facility with a catchment area of numerous communities which may make it difficult to extract data from specific communities.

5. Surveillance systems: some diseases and other health conditions such as polio or measles are actively tracked by public health officials and can serve as a source of information for the baseline.

*Advantages:* ongoing system that is usually supported by other resources.

*Disadvantages:* as you raise awareness in the community about the issue, you may find that the number of reported cases actually increases, not because the situation is actually worsening but because more people have come forward with new cases. This is not unusual but needs to be factored into any analysis later on.

6. Situation analysis in health: includes health facility assessments, health care financing, review of health policies, collection of health services utilization data, and other related information to provide the user with information about the health system and how it is used.

*Advantages:* provides a lot of relevant information, particularly on health service quality and coverage.

*Disadvantages:* usually need external assistance and high level of technical capacity to carry it out. Can be costly.

7. Process diagnosis: in some ways a more qualitative tool, the process diagnosis helps to look at what happens on the path to survival and good health to determine where the majority of individuals or families

who have poor outcomes have had difficulty preventing or resolving a problem. (See the Warmi project case study for a description of the “Pathway to Survival!”) Similarly, you could look at what families with optimal outcomes have done.

*Advantages:* This tool helps project teams and communities to weight their interventions more heavily on where individuals or families with poor outcomes “fall off the path.”

*Disadvantages:* requires trained people to interview families who have experienced death or serious complications. Results should not be interpreted as having to focus only on areas of greatest “fall-out” because all steps along the pathway are important to maintain.

8. Secondary data source review: other existing documents that compare the community’s status vis-à-vis the health issue with that of other communities in the country and perhaps in neighboring countries. The purpose of this exercise is to provide participants with a broader view of how their health compares with others. This exercise is particularly important when a community’s health status is poor compared with others and the community’s awareness of and interest in this health issue is low. Using a more appreciative approach, you may want to highlight the advances made in the past in the community related to the health issue and demonstrate that further improvement is possible by sharing experience from other communities.



## IV. A Sample Community Mobilization Plan (Step 5, pages 23-29)



The following is an example of a mobilization plan that was drawn up for the Bridges project in Peru. We have taken the original Bridges plan (which predated this field guide) and adapted it to fit the seven elements of a community mobilization plan described in Step 5 of this chapter.

### **BUILDING BRIDGES TO QUALITY**

#### ***Community Mobilization to Improve the Quality of Health Services from the Community and Client Perspectives***

### **1. Background Information**

In rural areas of Puno in Peru, health services are underutilized. Those people who have used the services are often dissatisfied with the care that they receive. The results of a *rapid communication needs assessment* conducted by JHU/CCP-Project 2000 indicated that clients' satisfaction with health services was primarily determined by how they were treated by the provider. The providers' concept of an "ideal client" is someone who is responsible for his/her health, communicative, speaks Spanish, and has attained a certain level of culture and education. In the rural areas of Puno, most clients do not fit this description. There is a large cultural and socio-economic gap between service providers and clients—the higher the educational level, the bigger the gap. Many providers recognize that their relationships with communities and clients need to be improved, but often they perceive that it is their clients who need to change. Few providers see the need for changes in their own behavior. Communication between providers and clients is usually vertical, often paternalistic, and infrequently horizontal. Clients are often afraid to ask questions and service providers do little to encourage them.<sup>5</sup>

<sup>5</sup>A full summary of the results can be found in the reports, *Evaluación/Diagnóstico Rápido de Necesidades de Comunicación* and *El Reto de una cultura de calidad: Responder al/a cliente senti-pensante*. Johns Hopkins University/Center for Communication Programs, 1997.

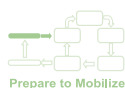


Efforts to improve the quality of health services in developing countries have traditionally focused on strengthening clinicians' technical and counseling skills through a variety of training designs. Generally, when input from clients and communities on how they define quality is sought at all, it is through formative research, focus group discussions, or interviews. The resulting training curricula or protocols attempt to incorporate what is learned from this formative research. This approach treats the client/community as the object of services and not as active participants in improving quality. While services may improve using this approach, the process does not foster community participation in, and ownership of, the services.

Community mobilization to improve the quality of health services using a problem-posing approach is emerging as an alternative. Using this approach, community members and service providers enter into an ongoing respectful dialogue about how to improve health and what constitutes quality services. The community and service providers identify priorities and develop strategies *together* to improve health services and practices. The underlying assumption is that if community members act as partners with health care providers to define quality and improve services based on this definition, the resulting services will more appropriately address the needs of the population, community resources can be mobilized to this end, and community members will ultimately develop ownership of their health services.

Puno was selected as a potential demonstration project site to improve the quality of health services from the clients' and community's perspective. JHU/CCP and USAID staff chose Puno because of: 1) Puno government health workers' expressed interest in making positive changes to improve their services; 2) a demonstrated need based on health services indicators; 3) government health workers' positive previous experiences and training working with JHU/CCP on health communication programs.

This proposal presents JHU/PCS-Peru's innovative approach to improving the quality of health services from the client and community perspective and increasing community ownership and use of public health services in the rural areas of Puno.



## 2. Program Goal

This project aims to develop and strengthen shared responsibility for public health services between communities and health service providers in selected project areas to contribute to the improvement of the population's reproductive and general health.

## 3. Program Objectives

During the two-year project, JHU/PCS will provide assistance to the Ministry of Health (MOH) Puno subregion in selected pilot areas to:

1. Increase the utilization of public health services in selected project areas.
2. Improve client and service provider interpersonal interactions within health services.
3. Establish mechanisms and/or systems to improve coordination and collaboration between health services and community organizations.

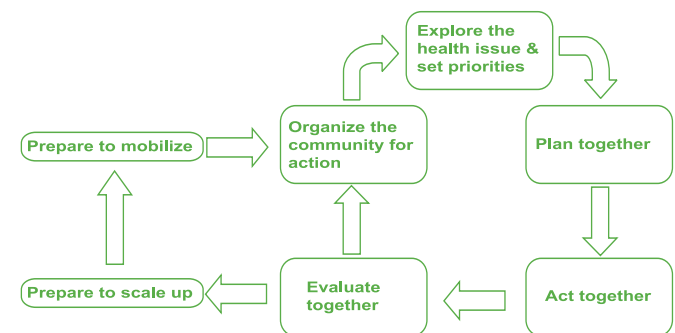
## 4. The Community Mobilization Process (the Community Action Cycle)

This section presents a summary of activities for the first project year.

### I. Prepare to Mobilize

*Establish a core implementation team at the subregion level.*

Determine with subregion directors who will coordinate the project and who would be appropriate to serve on a core implementation team (i.e., the community mobilization program team). Team members will be responsible for planning, implementing, and monitoring the project with technical assistance from the JHU/PCS Peru team. Eventually, this team will assume full responsibility on behalf of MOH to facilitate community mobilization efforts to improve health and health care services in the subregion. The most important criterion for selection for this group is respect for,



understanding of, and interest in communities' perspectives. Prior experience in participatory training, participatory methods, field work with communities, and an understanding of traditional practices should also be included in the selection criteria.

*Select a project area in the Puno subregion.*

The JHU/PCS-Peru team will work with Puno subregion staff and USAID/Peru to determine where the project will initiate pilot activities. Some suggested criteria for selection of this site include:

- Communities and health staff express interest in participating in the project.
- Communities and/or service providers have identified the need to improve their relations.
- Communities are fairly well organized.
- Women will be included in the project process.
- Utilization of health services is low.
- Health indicators are relatively poor compared to other areas.
- Higher percentage of facilities that are co-administered by providers and communities in the district.
- Existence of other organizations who are working there.

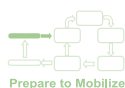
*Train the core team.*

To strengthen core team members' capacity to implement this project, the JHU/PCS-Peru team will conduct a 5-day workshop that will include: adult learning principles; community mobilization principles, strategies, and methods; facilitation skills; participatory techniques; interpersonal communication skills; and, other relevant topics.

## **II. Organize the Community for Action**

*Select community and service provider participants.*

The core team will determine criteria to be used to select participants in the dialogue process. It is very important that participants be truly representative of the community and service provider populations and not just people who are appointed to do this by formal officials.



Recommended community participants include (approximately 25 total):

- Official community leaders.
- Representatives from community organizations.
- Women and men of varying economic means who are interested in improving the community's health (selected by the community to represent them, Spanish and non-Spanish speakers, literate and non-literate).
- Young people (adolescents) who are interested in improving their health services (selected by their peers to represent them).
- Traditional or informal leaders.
- Others as determined by the communities.

Recommended health service provider participants include (approximately 25 total):

- Director of the Health District.
- Directors of key divisions/departments (maternal and child health, family planning, community participation).
- Representatives from health posts, center and the hospital at each level (technicians, nurses, doctors, obstetricians, social workers).
- Others as determined by district health personnel.

### III. Explore the Health Issue and Set Priorities

*Develop and produce two participatory videos: one with service providers and one with community members that depict each group's vision of high quality health services and positive client/community-provider relationships.*

The JHU/PCS-Peru team will work with the subregional core team to develop facilitation guide(s) to assist the two groups (community members and service providers) with the production of the participatory videos. The facilitation guide(s) will include objectives of the video (e.g., to serve as a catalyst to initiate dialogue with the other group about this group's vision of quality services and

positive relationships and how these could be improved from the current reality) and some key questions to help the groups begin to articulate their thoughts.

The core team will meet with communities in the selected project district to explain the purpose of the project and invite their participation. Those communities that are interested in participating will be included in the project. (Core team members will need to specify criteria for participation if the area has too many communities to include in this first project phase.)

The core team will also meet with health service providers from the project area hospital, health centers, and health posts to explain the purpose of the project and select participants.

Members of the core team and JHU/PCS-Peru staff will assist both groups with the development of content for the videos using participatory techniques. They will help the groups to determine how they would like to express the content on film and will teach them how to use the video camera.

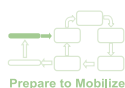
Each group will plan and conduct their filming. JHU/PCS-Peru staff and MOH communications staff will assist with editing the final product.

#### IV. Plan Together

*Initiate a respectful dialogue between service providers and community members that produces a draft action plan to improve the quality of health services from the client and community perspectives and establishes coordination and collaboration mechanisms between health services and community groups.*

The core team and JHU/PCS-Peru staff will meet with both groups to determine the date for a two-day meeting aimed at jointly defining what quality of care is and developing a joint action plan to improve quality.

The core team and JHU/PCS-Peru staff will identify at least two facilitators for this meeting. The facilitators must be very experienced, sensitive to cross-cultural



communication issues, speak Spanish and Quechua/Aymara, be familiar with health services issues, and be acceptable to both groups (perceived as unbiased).

During the meeting, participants will:

- Get to know each other and the different worlds in which they live.
- Do some preparatory exercises before viewing the videos.
- See the videos.
- Process their experience of the videos.
- Identify common themes and differences in perspectives related to quality services.
- Develop a common vision of what quality health services are.
- Identify barriers to achieving this vision.
- Develop and negotiate strategies and concrete actions to minimize these barriers.
- Prepare a draft action plan.

*Reach consensus on the action plan.*

Service providers will return to their health facilities and community participants will return to their communities. They will explain to their colleagues, neighbors, friends, and others what happened in the meeting. They will present the draft plan and will discuss it to determine whether there are any revisions that need to be made, whether it is feasible, and whether all in the community or service site support the plan. Those who participated in the development of the plan will make note of any questions, suggestions, and comments so that they can be shared with other plan developers when they meet again.

*Formally agree to the plan.*

The original participants return to meet together to share the input that they have received from their organizations/communities. They negotiate and revise the plan where necessary. A “final” version of the plan is written (recognizing that plans can still be flexible and change if they need to be changed). All participants sign the document. (Project staff and meeting participants should ensure that those decision-makers who formally represent the community and health

institutions are present so that their signatures are included on this document.) Copies of the document should be distributed (at a minimum) to the formal community representatives and to each health service site.

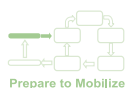
## V. Act Together

### *Implement the action plan.*

Community members and service providers will carry out the activities in the plan. The core team and JHU/PCS-Peru staff will provide technical assistance as necessary to support community and service provider actions. When needed support is not within the scope of core team or JHU/PCS-Peru staff expertise, this team will assist in identifying other resources that may be accessed. In some cases, community members may need to try to link with other organizations directly.

### *Monitor project progress.*

Communities and service providers will monitor their progress according to the mechanisms that they have established during their planning phase. JHU/PCS-Peru and the core team will also monitor project progress and will ensure that some key indicators (quantitative and qualitative) are being measured. (These indicators need to be agreed to during the planning phase of the project. Qualitative indicators should reflect the providers' and communities' vision of quality services. At a minimum, basic service statistics should be monitored.) The JHU/PCS-Peru team and core implementation team will establish mechanisms such as monthly meetings and/or quarterly evaluation and planning meetings to monitor project progress, strengthen their own capacity as a team to facilitate this process, and document results over time. Quarterly progress reports will document the project process and results. They will be disseminated to USAID/Peru, MOH staff as appropriate, JHU/PCS Baltimore, and others as determined by project and donor staff. They will also serve to help orient new team members and as a reference for future teams in other sites. These reports should include a section on "lessons learned" as well as narrative describing what happened during the quarter and results of these efforts. A copy of any materials or products completed by the participating communities and health services should also be included.





## VI. Evaluate Together

*Conduct participatory evaluation of the project.*

JHU/PCS-Peru staff (possibly with a participatory evaluation specialist) and the core team will assist the project implementers to determine what kind of evaluation they would like to conduct, who should participate in the evaluation, and how the evaluation should be conducted. They will help the evaluation team to develop evaluation methods to determine whether the community has met its objectives. They will prepare evaluation materials as necessary and will assist with training evaluation team members. In addition to the evaluation team members who have participated in the project, it is recommended that at least one or two external evaluators participate to provide a more objective perspective and to introduce these people to the process that has been followed in this pilot project (possibly decision-makers from other areas that may be interested in using the methodology).

Indicators will need to be developed that can serve to measure whether the project is approaching its ultimate goal of increased community ownership and its objective to increase the use of health services. Indicators to measure use of health services are relatively straightforward; ownership indicators are not as clear-cut. The concept of community ownership needs to be addressed throughout the project process. While illustrative indicators could be suggested, it is better to explore these with community members and health service providers to determine some measures that reflect these groups' understanding of what "ownership" means.

## VII. Prepare to Scale Up

*Expand the project to new areas .*

If all goes well and the methodology followed in this pilot project is successful in improving the quality of health services and increasing community ownership of these services, the process can be adapted for use in other interested areas of Peru as funding and other resources allow.

## 5. Monitoring and Evaluation Plan

Three approaches to community can be distinguished in community-based interventions. The most common refers to community as “groups of people” to be reached, with interventions trying to reach as many people as possible with the program message. A second approach is the view of community as “setting,” where characteristics of the community are used as levers to assist program-directed change processes, and to support and maintain individual behavior change. The third approach, which is the one followed for the current project, is to see the community as an “ecosystem” or social system, with capacity to work towards solutions to its own community identified problems (Hawe, 1994).

As may be expected, project impact and evaluation design will vary substantially according to the approach to community that is followed. For the current project, the evaluation design will consider the broader definition of community (as social system) used in the intervention, and should attempt to capture program outcomes, such as changes in community processes and structures, and the extent to which the project met its objectives. Such an evaluation requires the identification of indicators at three different levels: individual, organizational, and community level. Likewise, the evaluation design should apply techniques and methods that allow for more complete measurements of individual, organizational, and community effects. Methods should go beyond closed questions that cannot capture the richness and complexity of the individual and community processes. We propose the simultaneous use of both quantitative and participatory qualitative methods such as in-depth semi-structured interviews, focus groups, community group exercises and observations. The combination of these methodologies will allow a better assessment of processes and outcomes at the different levels and triangulation of results.

Some of the evaluation options are as follows:

### Client Perspective

- *Focus groups* with clients and potential clients: Purpose is the identification of quality issues as seen by the client and potential clients. Baseline data (JHU/



CCP Rapid Needs Assessment, 1997) exists and was used to address quality issues in the current intervention. Data collection of the same type would allow for identification of changes in perceptions of quality of care and changes that are occurring in the provision of services.

- *Client exit interviews.* This technique was also used for baseline data collection and could be used once again, based on observed sessions, to compare with baseline results. Two waves of data collection are recommended during the life of the project to observe changes over time.
- *In-depth interviews* with long term clients. Can be used to assess perception of changes in providers' behavior and in health sites during the intervention period. This method can also be used to assess client's changes in his/her own health behavior.

### Client-Provider Interpersonal Communication

- *Direct observations of client-provider communication.* Poor client-provider communication was identified as one of the main issues in the baseline data (JHU/CCP Rapid Needs Assessment, 1997). A training course on interpersonal communication (IPC) was not given because baseline results showed that providers were aware of IPC skills. Instead, a community-based approach was chosen. To examine changes in client-provider communication, two data collection exercises are proposed. One at the midpoint of the project to identify issues that need to be addressed during the intervention and a second one at the end to examine progress over time.

### Provider Perspective

- *In-depth interviews with providers:* Another important result from the baseline evaluation was the provider's perspective on quality of care and his/her view of clients. This same technique is proposed to obtain comparable information that can be contrasted with baseline results with respect to providers perceptions of clients, their role in quality care, and changes in their own attitudes and behaviors with respect to clients and the community. Likewise, data should obtain providers' personal lessons learned from the project.

- *Focus groups with providers:* Purpose is to examine organizational support or constraints to providers' work in the community, as well as other related issues that may interfere in providers' intentions to change his/her behavior and approach to the community. Information gathered can be used to address problems at different levels of the health services that may hinder providers' efforts.

### Community Perspective

- *Clinic service statistics:* These data will be used as a monitoring tool for the utilization of services. It is expected that improved service provision will result in increased use of services, increased number of new users, and use of different types of services (e.g., immunizations; pregnancy control; deliveries). Regular record-keeping of services in clinic sites will be used for this purpose and data will be limited to available information in the records.
- *In depth interviews with community leaders and other key respondents:* Purpose is to obtain changes in community perceptions about the health services and community involvement in their own health. Likewise, changes in community processes can be tracked through these type of interviews. Perceptions of change in different dimensions of community capacity can also be assessed through interviews with leaders and other key respondents in the community. Some of the community dimensions to assess may be, but not limited to: community participation, leadership, skills, resource, organization and structure, community networks, sense of community, and community power.
- *Population-based survey:* To identify other health behaviors within the families that are related to participation in the project. Likewise, the survey can examine changes in the individual's knowledge and attitudes toward the health services and their own perceptions of health and health behaviors.
- *Follow-up of selected families:* This technique can be used as an alternative or in combination with the population-based survey to monitor more in-depth changes in family attitudes, perceptions, beliefs and health behaviors. This



method requires the participation over the duration of the project of selected families. Data will be collected through periodic visits by the program team and by the families, using previously designed ad-hoc family records.

- *Community self-assessment:* On-going community evaluations of their action plans, level of participation, decisions and actions taken are a very important component of project evaluation. Documentation of these community processes by the same community could be encouraged as they reflect relevant project effects. Additionally, community participants will be involved in the design and conduct of the annual evaluation so that their questions will be included and they will learn first-hand how an evaluation can help them to improve their program. Additionally, representatives from one community will participate in the evaluation of another community to learn from others' experience.

### **Program Team Perspective**

- *Record keeping of community processes:* Direct observation and documentation of community actions, organization and structures, networking, participation, and so forth, as they relate to improved coordination with health services and community well-being. This technique has the purpose of getting the program team perspective of community-mobilization to reach their goals. Categories for documentation of these processes may be related but not limited to some of the dimensions, previously mentioned, of community capacity. Analysis of current team reports should provide the basis for future report writing and recording of community events and issues that are related to the project.

### **Improved Coordination and Collaboration (Health Services and Community views)**

- *In-depth interviews with leaders and key respondents from the community and health services side:* Purpose is to identify from each side, actions that have improved coordination and collaboration between health services and community organizations. Likewise, attention should focus on problems

identified for gaining these improvements, solutions envisioned and future actions for sustained relations.

- *Testimonial Videos:* Videos from both the community and the providers can be used as a baseline for the project and should be analyzed to examine several health and non-health issues at the community level and for the organization of services. Similar video exercises may be conducted at the end of the project (possibly at the midpoint of the project also) to analyze changes in the identified issues. Relevant categories for community and health services levels will be developed from the analysis of the baseline material.

For some of the evaluation options mentioned above (such as client perceptions of quality of care, providers' perceptions, and client-provider interpersonal communication) baseline data exists, and a pre/post-evaluation design can be used. There is a need, however, for a comparison group for indicators related to community effects. To cover this need, a community with similar characteristics of those in the intervention sites should be identified. Similar data related to actions that apply at the community level will be recorded in the comparison community and later compared with those in the intervention sites.

## 6. Project Management Plan

JHU/PCS-Peru will contract a Project Advisor/Manager who will be based in Puno. S/he will: with MOH Project Coordinator, coordinate project activities; manage project resources at the local level; identify appropriate consultants if necessary; liaise with MOH staff, particularly the core team, at the subregional level; and, provide technical assistance throughout the project in communications and participatory approaches to working with communities (especially participatory video development). S/he will ensure that project indicators are monitored and that project process and results are documented well. S/he will ensure that logistical arrangements for workshops and meetings are made. S/he will report to the JHU/PCS-Peru Program Manager in Lima.



JHU/PCS Baltimore's Sr. Program Officer for LAC will provide technical assistance and oversight to the JHU/PCS-Peru team. Save the Children Federation, Inc., a subcontractor to JHU on the PCS4 Project, will provide technical assistance in project design, training curriculum development, participatory techniques, project monitoring and troubleshooting, and will assist with the evaluation design.

A core team composed of MOH subregional staff will be responsible for day-to-day management of the project. It is suggested that someone from this team be named as a formal Project Coordinator; however, vertical relationships within the team should be discouraged. The team's capacity to facilitate community mobilization will be strengthened through formal workshops and through hands-on experience in the field. The core team members will determine how often they would like to meet to plan, monitor and evaluate project activities. It is suggested that these meetings be held monthly if possible. One or two facilitators will likely be needed to facilitate the two major group meetings (see activities section for criteria for selection).

In communities, management and coordination structures should be determined by community members (and local service providers, if appropriate). It is important that core team members and other project staff not impose any particular structure such as a committee. If community members determine that a committee or other type of organization is needed, they will establish one.

## 7. Budget

Many organizations, such as JHU/CCP, have their own budgeting formats and systems in place. If you are working with an organization that does not have such a system in place, you should include the following elements in developing a budget. Remember to consider the short and long-term implications of using external resources to cover costs that should ultimately be assumed by the community.

**Salaries/honoraria** (if applicable)

Job titles, level of effort (Number of people @daily rate x number of days x number of months)

**Fringe benefits** (if applicable)

**Consultants:**

Type of consultant (Number of days x daily rate)

**Travel and transportation:**

Fuel

Vehicle maintenance (if applicable)

Fares (Number of trips x amount per trip)

Accommodation/lodging (Number of days x amount per day)

Meals (Number of meals x amount per meal)

**Equipment, materials, and supplies:**

Training materials

Office supplies

Other as needed (videotape, cassettes, etc.)

**Other direct costs:**

Workshops (Number of workshop x average cost per workshop)

Communications (phone, fax, postage, etc.)

Reproduction/copies

Other costs that your organization may charge (rent, utilities, etc.)

Tuition/training fees

**General and administrative costs/overhead/indirect costs**

**Total cost**



Prepare to Mobilize



## V. Key Elements of Community Mobilization: A Team-Building Discussion Guide (Step 6, pages 29-32)

This tool will help the program team understand some of the key elements of community mobilization. It is a useful exercise in developing your team and helping them work more cohesively as a group.

Hand out the following list of terms to participants (or write each of them on a separate piece of flipchart paper and then tape them to the walls around the meeting room).

**Human rights**  
**Community**  
**Health**  
**Culture**  
**Gender**  
**Education**  
**Communication**  
**Mobilization**  
**Participation**  
**Dialogue of knowledge**  
**Power**  
**Equality**  
**Citizenship**  
**Role of institutions** (e.g., NGOs, State, churches, private enterprise)  
**Leadership**  
**Ethics**

Explain to your team that this is a list of key concepts in the field of community mobilization and that it is important for team members to have a common understanding of these terms. Then lead a discussion with the group, asking each member:



What does the term mean to you?  
How does the term apply to our CM effort?

Note any similarities and/or differences in perspective among the team members. If there are significant differences in opinion, discuss how this diversity may help or hinder the team's efforts in the community.



# Resources

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Here are some excellent resources for preparing yourself and your team as effective participatory facilitators for community mobilization:

## General

- Andreasen, A.R. (1995). *Marketing Social Change: Changing Behavior to Promote Health, Social development, and the Environment*. San Francisco: Jossey-Bass.
- Bhatnagar, B. and A.C. Williams. (1992). "Participatory Development and the World Bank – Potential Directions for Change." *The World Bank Discussion Papers*, No. 183.
- Buvinic, M. and M. Paolisso. (1996). *Taking Women Into Account: Lessons Learned from NGO Project Experience*. Washington, DC: International Center for Research on Women.
- Chambers, R. (1997). *Whose Reality Counts?* London: ITDG.
- GEM Initiative. (1996 & 1997). *Global Social Innovations: A Journal of the GEM Initiative*. Vol. 1 (1 & 2).
- Howard-Grabman, L. (2000). "Bridging the Gap Between Communities and Service Providers: Developing Accountability Through Community Mobilization Approaches." *Institute of Development Studies Bulletin*, Vol.31 (1):88-96.
- Howard-Grabman, L. et al. (1993). *The Warmi Project: A Participatory Approach to Improve Maternal and Neonatal Health – An Implementer's Manual*. Washington, DC: John Snow, Inc./MotherCare Project.
- Kanter, R. M. (1977). "Some effects of proportions on group life: Skewed sex ratios and responses to token women." *American Journal of Sociology*, 82:965-990.
- McKee, N. (1992). *Social Mobilization and Social Marketing in Developing Countries: Lessons for Communicators*. Penang, Malaysia: Southbound.
- Minkler, M. (ed.). (1997). *Community Organizing and Community Building for Health*. Rutgers, NJ: The State University Press.
- Oakley, P. (1995). *People's Participation in Development Projects*. London: INTRAC.

Overseas Development Administration. (1995). *A Guide to Social Analysis for Projects in Developing Countries*. London: HMSO.

Rifkin, S.B. (1996). "Paradigms Lost: Toward a new understanding of community participation in health programmes." *Acta Tropica*, Vol. 61:79-92.

### **Nonformal Participatory Learning**

Centre for Development and Population Activities. (1994). *Training Trainers for Development: Conducting a Workshop on Participatory Training Techniques*. Washington, DC: CEDPA.

Crone, C. D. and C. St. John Hunter (eds.). (1980). *From the Field – Tested Participatory Activities for Trainers*. Boston: World Education.

Deshler, D. (1995). *Participatory Action Research: Traditions and Major Assumptions*. Ithaca, NY: Cornell Participatory Action Research Network, Cornell University.

Easton, P. (1997). *Sharpening Our Tools: Improving Evaluation in Adult and Nonformal Education*. Hamburg, Germany: UNESCO.

Fox, H. (1989). *Nonformal Education Manual*. Washington, DC: Peace Corps. Information Collection and Exchange #M0042.

Freire, P. (1997). *Pedagogy of the Oppressed*. New York: Continuum Press.

Hope, A. and S. Timmel. (1986). *Training for Transformation—A Handbook for Community Workers, Vol. 1-3*. Gweru, Zimbabwe: Mambo Press.

Maddux, R.B. (1992). *Team Building: An Exercise in Leadership*. Los Altos, CA: Crisp Publication.

Owen, H. (1997). *Open Space Technology—A User's Guide*. San Francisco: Berrett-Koehler Publishers, Inc.

Parker, G. and R. Kropp. (1992). *50 Activities for Team Building, Vol. 1*. Amherst, MA: Human Resource Development Press.

Petit, A. (1994). *Secrets to Enliven Learning: How to Develop Extraordinary Self-Directed Training Materials*. San Francisco: Pfeiffer and Co.

Pfeiffer, J. W. (ed.). (1989). *The Encyclopedia of Group Activities – 150 Practical Designs for Successful Facilitating*. San Francisco: Pfeiffer and Co.

Save the Children. (1982). *Bridging the Gap: A Participatory Approach to Health and Nutrition Education*. Westport, CT: Save the Children/USA.

Schneier, C. E. (ed.). (1994). *The Training and Development Source Book*. Amherst, MA: Human Resource Development Press.



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- Silberman, M. (1995). *101 Ways to Make Training Active*. San Francisco: Jossey-Bass.
- Svendsen, D. S. and S. Wijetilleke. (1983). *Navamanga—Training Activities for Group Building, Health and Income Generation*. Washington, DC: Overseas Education Fund.
- Vella, J. K. et al. (1994). *Learning to Listen, Learning to Teach*. San Francisco: Jossey-Bass.
- . (1995). *Training Through Dialog: Promoting Effective Learning and Change with Adults*. San Francisco: Jossey-Bass.
- . (1997). "How Do They Know They Know?: Evaluating Adult Learning." *Higher and Adult Education Series*. San Francisco: Jossey-Bass.
- . (1997). *Learning to Teach—Training of Trainers for Community and Institutional Development*. Westport, CT: Save the Children/USA.
- Woodcock, M. and D. Francis. (1992). *25 Training Activities for Creating and Managing Change*. Amherst, MA: Human Resource Development Press.

### **Participatory Research**

- de Koning, K. and M. Martin. (1996). *Participatory Research in Health: Issues and Experiences*. London: Zed Books.
- Freudenberger, K. S. (1999). *Rapid Rural Appraisal and Participatory Rural Appraisal Manual: A manual for CRS Field Workers and Partners*. Baltimore: Catholic Relief Services.
- Parker, A. R., et al. (1995). *Gender Relations Analysis: A Guide for Trainers*. Westport, CT: Save the Children/USA.
- Peace Corps. (1996). *PACA: Participatory Analysis for Community Action*. Washington, D.C.: Peace Corps/Information, Collection and Exchange, #M0053, 69-77.
- Pretty, J. N., I. Gujit, J. Thompson, and I. Scoones. (1995). *Participatory Learning and Action: A Trainer's Guide*. London: International Institute for Environment and Development.
- Rennie, K. and N. Singh. (1996). *Participatory Research for Sustainable Livelihoods: A Guidebook for Field Projects*. Manitoba, Canada: IISD.
- Save the Children. (1982). *Bridging the Gap: A Participatory Approach to Health and Nutrition Education*. Westport, CT: Save the Children/USA.
- Selener, D. (1998). *Participatory Action Research and Social Change*. Ithaca, NY: Cornell Participatory Action Research Network, Cornell University.

Slocum, R., L. Wichart, D. Rocheleau, and B. Thomas-Slayter (eds.). (1995). *Power, Process and Participation – Tools for Change*. London: Intermediate Technology Publications.

### **Strength-Based Approach**

Cooperrider, D.L. & S. Srivastva. (1987). "Appreciative inquiry in organizational life." In R. Woodman & W. Pasmore (eds.). *Research in Organizational Change and Development*, Vol. 1: 129-169.

Hammond, S. A. (1998). *The Thin Book of Appreciative Inquiry (Thin Book Series)*. Plano, Texas: Thin Book Publishing Co.

Kretzmann, J. and J. McKnight. (1998). *A Guide to Creating a Neighborhood Information Exchange: Building Communities by Connecting Local Skills and Knowledge*. Chicago: ACTA Publications.

———. 1997). *A Guide to Capacity Inventories: Mobilizing the Community Skills of Local Residents*. Chicago: ACTA Publications.

———. (1993). *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*. Chicago: ACTA Publications.

Liebler, C. (1997). "Getting Comfortable with Appreciative Inquiry." *Global Social Innovations: A Journal of the GEM Initiative*, Vol. 1, Issue 2.

Sternin, J. and R. Choo. (2000). "The power of positive deviancy: an effort to reduce malnutrition in Vietnam offers an important lesson about managing change." *Harvard Business Review*, January-February, pp. 14-15.

Sternin, M., et al. (1998). *Designing a Community-Based Nutrition Program Using the Hearth Model and the Positive Deviance Approach – A Field Guide*. USAID/BASICS Project.

Weisbord, M. and S. Janoff. (1995). *Future-Search – An Action Guide to Finding Common Ground*. San Francisco: Berrett-Koehler Publishing, Inc.

### **Cross-Cultural Communication**

Fuglesang, A. (1982). *About Understanding—Ideas and Observations on Cross-cultural Communication*. New York: Decade Media Books.

McCaffery, J.A. (1986). "Creating Effective Training and Independent Effectiveness: A Reconstruction of Cross-Cultural Orientation and Training." *International Journal of Intercultural Relations*. Vol. 10, 159-178.

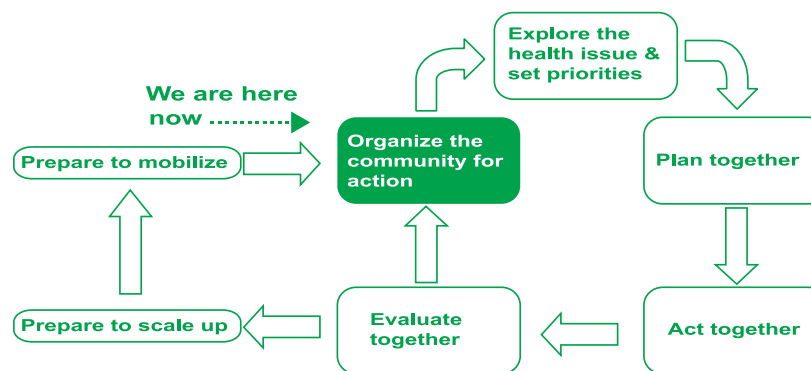
Storti, C. (1999). *Figuring Foreigners Out: A Practical Guide*. Yarmouth, ME: Intercultural Press.



# Chapter 2

## Organize the Community for Action

1. Orient the community
2. Build relationships, trust, credibility, and a sense of ownership with the community
3. Invite community participation
4. Develop a “core group” from the community



“As an individual I could do nothing.  
As a group we could find a way  
to solve each other’s problems.”

Community member, Rwanda

Now that you have completed your initial preparations and developed an overall design for community mobilization, it’s time to formally approach the community and begin their involvement in this effort.

### STEP 1: Orient the community.

The first step in organizing a community is to invite community members to an orientation about the mobilization program. This can be done at a general community meeting, through local radio, street drama, newspapers (if available), and other media. Meetings have the added advantage that participants can have their questions addressed quickly and personal relationships can be established. The time and venue of the meeting are usually set with local leaders who invite general participation of all community members. Notifying the community about the orientation meeting can be done at a prior community meeting, through local media such as radio, television, talking drums, town crier, schools, community organizations, and other groups.

It is important to determine who will convene the meeting in order to reach community members most affected by and interested in the CM health issue and others who take a general interest in community life. Remember that people often decide whether to attend a meeting, whether they *belong* at a meeting, not only on the basis of the subject of the meeting but on “whose” meeting it seems to be.

Depending on circumstances, you may be able to organize your meeting around other events that are happening in the community, such as:

- Critical incidents (e.g., a death in the community, epidemics).
- Common problems/issues.
- Traditional community events (e.g., marriage, birth, rites of passage).





- General development activities.
- Emergencies.
- Campaigns or special occasions organized within or outside of the community (e.g., national vaccination day, Earth Day, Mother's Day).
- Human rights activities (e.g., literacy or civic education classes emphasizing the right to health care, access to information).
- Sharing information on health status to raise public awareness.

Now you will need to plan the content of your own meeting: the topics you are going to cover, in what order, and who will be responsible for what content. Depending on your agenda, you may want to give some thought to who would be the best spokesperson for the various topics you plan to cover, which team member or community member the audience would most readily identify with or listen to on this particular topic.

Most orientation sessions include, at a minimum:

1. Participant and CM team member introductions.
2. An introduction to your organization and what it does/does not do.
3. A brief description of the process that the CM team proposes to use.
4. A discussion about the health issue this CM program will address.
5. A presentation of the program goals.
6. A discussion on how the participants will want to work together.
7. Determining next steps: when and where the next meeting will be.



### An Example of Organizing around Role Models

Some programs that involve women's groups start with a series of visits to explain the program to community leaders and potential members. In breastfeeding promotion projects, community organizers visit the community to determine whether an existing NGO or other community-based health or service organization would be able to collaborate in breastfeeding promotion. If no appropriate organization is found, the organizers contact local officials and other formal leaders to gain their support. After several community members supportive of breastfeeding have been identified, the community organizers assist them in making outreach presentations to community groups, NGOs, mothers clubs, neighborhood health committees, churches, and schools (Rosenberg and Joya de Suarez, 1996).

*From Mother Support Groups: A Review of Experience in Developing Countries, BASICS 1998.*

## Be careful not to preempt the community

Some CM teams have decided prior to the orientation meeting how they would like the community to work with them, such as by forming a health committee or selecting community volunteer health workers, even though these entities may not have existed previously in the community. The CM team then uses the orientation meeting to put this preselected strategy into effect by having those present elect or appoint committee members or volunteer workers who will assume responsibility for the CM program and serve as the community's formal liaison with the team. This strategy may be effective in some situations, such as when community members are highly aware of their health needs and see the value in establishing such mechanisms.

But in many situations, this may not be the case. The volunteer health worker may be selected because the external organization (e.g., NGO, MOH) has made this a necessary condition for accessing external resources the community may need or want. However, if community members had done their own analysis of the particular health issue, their needs, and resources, they might have developed other more appropriate means of addressing their health needs. Or they may have determined that a health committee was indeed the most appropriate mechanism.

When communities do not see the need for a health committee or volunteer health workers, they do not support them. While it may be more convenient for outside organizations such as yours to work through committees, unless the community sees the need for such entities, these committees and/or volunteers will often have limited impact and are more likely to cease functioning when external assistance is withdrawn.

At the same time, when health committees, community health volunteers, or other groups already exist, it is important not to limit the orientation about the CM health issue only to these groups. You should, rather, involve these people in helping you put together an orientation for the wider community. You should also remember that while health committees and volunteer workers have



Organize the Community for Action

considerable experience working in the community and well-developed social and political networks that can be very valuable to any community mobilization effort, they won't necessarily be interested in the particular CM health issue you have chosen. A health committee established to increase vaccination coverage, for example, may or may not be particularly concerned about increasing access to family planning services. And you should, therefore, be careful not to limit your orientation meeting just to this group.

In short, while conventional wisdom advises working through existing community structures and organizations, and there often are good reasons to do so, this strategy may not be the best, particularly if these groups are not at all representative of the people who are most affected by and interested in the issue. (See Useful Tools I and II at the end of this chapter for more information about the community orientation.)

**When communities do not see the need for a health committee or volunteer health workers, they do not support them.**



## STEP 2: Build trust, credibility, and a sense of ownership with the community.

It's important for you and your team to take time to establish trust and credibility in the community and develop ownership of the CM effort among community members. To these ends, field workers have typically used strategies like the following:

- Identify an activity that community members enjoy, such as a sporting event, knitting circle, or community fair, and work with the community to help organize the activity. The activity may or may not have anything to do with your health issue.
- Establish meeting times and places based on community members' availability and local calendars, taking planting and harvesting into account, for example, and having meeting at times when most people are available (weekends, afternoons, or evenings).



**It is important for you and your team to take time to establish trust and credibility in the community and develop ownership of the CM effort among community members.**

- Encourage participants at every meeting to keep what is said in the group confidential and make sure that it remains confidential outside of the group if this is important to participants. This may be particularly important when discussing reproductive and sexual health practices and other sensitive issues.
- Help to create safe spaces in which participants can express themselves freely by validating participants' feelings, respecting differences of opinion, and assisting groups to prevent conflict or resolve conflict when necessary.
- Be honest and transparent.
- Ensure that all members of your team communicate consistently with community members, which means *all* team members need to embrace the program philosophy, be well informed about program activities, and be able to explain them to community members. Inconsistency in team members' communication quickly translates into community confusion and distrust.
- Call community members' attention to times when they do not fulfill their promises and commitments, in a respectful way that promotes reflection and fosters greater accountability.
- Apologize and accept responsibility when mistakes are made or promises are broken.
- Learn about and accept where community individuals and groups are in their own development, skills, knowledge, and organization and build on their strengths—rather than starting from where you may assume or think they should be. Exercises in getting to know one another and learning about the world in which each of us lives are helpful to demonstrate how context and experience shape our attitudes and behavior. They can also help develop a sense of empathy and compassion.

### STEP 3: Invite community participation.

Early on in the Organize the Community for Action phase, you need to identify those people and groups who are most affected by and interested in the CM health issue and invite them to participate in the program. These are the people



Organize the Community for Action



who most directly experience the effects of the problem and who need to be involved in finding appropriate solutions. You may also want to consider inviting those who are successfully dealing with the problem despite difficult circumstances, the “positive deviants,” to share their experience. While some of these people will no doubt attend the community orientations described earlier, it is important to be proactive in identifying others who may not immediately come forward for a variety of reasons. In most cases, this can be done by looking at epidemiological data to identify demographic/geographic patterns (if available), consulting community organizations and leaders, and inviting participation at general community meetings through local media and other means.

Development agencies have tried many different approaches to involve community groups. These approaches are usually based on the goals of the program, the organization’s development philosophy, the assumptions the program team makes, and the program’s resources and constraints. Here are some examples of strategies that have been used to invite community participation.

- The CM program team holds several meetings with local leaders and/or specific community groups to explain the program’s goals and objectives, the approach the team is taking, details about the strategy they are using, and logistics. The leaders then introduce program team members to the broader community at a regularly scheduled general community meeting, or they may announce a special meeting if no regular meeting is planned. The invitation to attend is through formal, pre-existing community communication channels or may be through house-to-house visits to deliver personal invitations or through local media.

### VIETNAM: Humor

Trust took time to build in the PANP community mobilization project in Vietnam, given that the initial SC team did not speak Vietnamese, that collaboration between SC communities had initially been directed by district officials, and that SC was one of the first American organizations working in post-war Vietnam. “Trust was established through clarity of purpose,” a staff member later observed, “[through] transparency of intention, mutual respect, working side by side, learning from each other, admitting and learning from mistakes, celebrating small successes, and *humor, humor, humor.*”

*Monique Sternin, SC Vietnam*



## MOZAMBIQUE: Building Trust

In 1988 in Mozambique, local authorities were initially skeptical about a U.S.-based organization working in a socialist political environment. Likewise, mobilization of communities was often linked to political causes or 'events' and not necessarily to participation in health-related activities. In many cases 'participation' was mandatory to show political support rather than a response to a genuine community need. In order to create the necessary trust to begin to work with communities, the program team used a number of strategies including:

- Holding initial meetings with community and local leaders to assess interest and ask permission to work with community.
- Conducting introductory meetings in all barrios (community neighborhoods) focused on: who they were (emphasis on nonpolitical, nonreligious nature of organization); the health and development goals of the program; and the participatory, empowering approach the team was committed to.
- Organizing youth group and barrio leaders for a community mapping exercise.
- Organizing house-to-house numbering for a health information system.
- Conducting voluntary family registration (collection of health and demographic information) in combination with a growth monitoring and vaccination session.
- Holding feedback sessions in all barrios on health status and demographic data (e.g., how many children <5, women of child-bearing age, number of children and women vaccinated, percent malnourished/well-nourished).

The family registration process was not mandatory. The teams for the initial registration were easily accessible in each barrio. Information on the day and time was made available by using signs in the local Shangaan language. It was a demonstration of desire and 'true participation' that nearly 98% of all the families turned out during their barrio registration day. Men's participation was high, as heads of household were encouraged to be present. Having men participate in their families' health and experiencing work with the NGO first-hand was a powerful way to gain support and trust for further collaboration.

*Save the Children Federation (US), Mozambique field office*

- The program team identifies community organizations that are already working on health issues and asks to be included on the agenda for an upcoming meeting. Those who attend the meeting are already engaged in similar activities and may or may not be directly affected by the specific CM health issue. This approach limits the initial group of attendees to those who are already interested in similar issues.
- The program team undertakes a study of social networks in the community to identify those key people who communicate with and influence many others on subjects like the CM health issue. These individuals are then invited to a community organizing meeting, along with others who are interested in or affected by the issue.

"Participation" has become popular in community development circles, and some community mobilizers may be under pressure to demonstrate an especially high level of participation. This pressure may come from donors, supervisors, community members, or others or may be self-imposed. To ensure high participation, teams may make promises of material gain or other incentives. In the short run, incentives for participation may yield great attendance. However, incentives do not set a good precedent, and when the incentives stop, so will most participation. It is usually preferable to work with a small, committed group that does not need enticements other than the opportunity to learn and the chance to improve the health of their families and the community.





## Factors which influence participation<sup>1</sup>

An individual's decision to participate in collective action for health is based on a number of factors; some are community related and others are personal. This section briefly summarizes examples of both.

### Community-related factors

- The magnitude of the problem: an objective measure of the prevalence or extent of the problem.
- A history of community support: includes the presence of organizations or agencies involved in the issue, the presence of traditional systems for dealing with the issue, the amount of effort and resources expended on the issue in a defined period of time by any sources within the community.
- The existence of personal networks: similar to the above item, this factor refers to the number, strength and connectedness of various networks people belong to in the community, whether any of these extend beyond the community (and could be sources of support and resources), and the presence of leaders in such networks.
- The availability of resources related to the issue: includes the availability of information about the issue within the community, the presence of channels of communication that carry information about the issue, the amount of money and other resources available for the community to use in addressing the issue, and the presence of alternative practices/behaviors that could substitute for or alleviate the problem.
- A history of external support: includes past and present policy, legal, financial, or infrastructure support from outside the community for the issue (e.g., donor funding, technical assistance, enforcement, staffing of local health service sites, supplies).

### SENEGAL: The Importance of Grandmothers

In Senegal, participatory, formative research identified grandmothers as being key decision-makers and very influential in maternal and child health practices. The project focused on reinforcing the grandmother's role through songs of praise and other public means and successfully involved grandmothers in mobilizing the rest of the community around healthier maternal and child practices.

*Christian Children's Fund, reported by Judi Aubel, 2001*

<sup>1</sup> The factors presented in this section were developed by the JHU/PCS4 Community Mobilization Task Force. We would particularly like to acknowledge J. Douglas Storey, Robert Ainslie, Gary Lewis, Marc Boulay, Antje Becker, Maria Elena Figueroa, Elizabeth Thomas, and other task force members for their contributions.





## RWANDA: The Dependency Syndrome

A unique feature of one NGO's work in war torn Rwanda was its philosophy of nonmaterial assistance. At a time when millions of dollars were flowing into the country to respond to the Rwandan tragedy, the NGO focused its energies on building the community's capacity to identify and care for children and did not supply traditional material emergency relief. This decision was based on the belief that there was a greater need to encourage self-reliance in order to avoid what is typically referred to as a "dependence syndrome" in emergencies. In the direct aftermath of the war, many community members were not interested in participating in an activity that did not provide immediate material benefits.

Once material assistance begins to dwindle, however, communities were appreciative of the NGO's approach and felt empowered to care for the children in their communities without outside assistance. "As an individual I could do nothing," one member of a Rwandan community observed. "As a group we could find a way to solve each other's problems."

*Save the Children Federation (US), Rwanda field office*



- Prior community action: the extent to which collective action, in general and/or specific to the issue, has previously occurred in the community. This factor is sometimes called collective efficacy, the belief that the group/community is capable of accomplishing a task by working together. It is obviously influenced by some of the previous factors.
- Subjective norms: refers to perceptions of what other people do or think should be done about a particular issue, including the perception of how acceptable collective action is on this issue.

### Personal factors

- Personal involvement: the degree to which people have direct personal experience with an issue.
  - Perceived self-efficacy: refers to a person's belief that he/ she is personally capable of performing a particular task.
- 
- Prior personal participation in collective action: the number of times people have done something as a group, either in a generic sense or with regard to the issue at hand.
  - Strength of identification with the community: the degree to which people recognize the group affected by an issue as a community, and/or the degree to which they feel they belong to the group affected by the issue in question.
  - Perceived consequences of change: refers to an individual's perception of what the consequences of change are vis-à-vis the issue. What will happen to me if I do this? If I don't? If my community does/does not? What are the costs and benefits for me/my community?



Each of the personal factors may be positive or negative, strong or weak in any given situation. The stronger and more positive they are, the more likely people in the community are to want to participate and to actually take part in collective action. Some of the predictors may be positive, but if they are outweighed by a particularly strong negative factor, intent will remain low. For example, a person may believe that digging a community well would be beneficial (positive consequence) and that his/her neighbors think so, too, but if he/she doesn't think the equipment needed to dig a well is available (availability of resources), the intent to act will remain low.

### Raising awareness

Participation (or the lack thereof) is also a function of whether or not people are aware of and concerned about the particular health issue. Where awareness and concern are high, it is generally much easier to stimulate participation. In this case, all you may need to do is be sure that community members hear about the program and know that they are invited to participate in meetings and activities. The CM program team should also decide how to balance participation so that those who need to be heard have the opportunity to have a voice.

Where awareness and concern are low, however, the CM program team will need to direct its attention to raising awareness. This can be done in a variety of ways, including:

- Identifying those individuals and groups that have the most direct experience with the CM health issue, even if there may only be a small number who want to participate at first.
- Launching a general awareness campaign through local media, community meetings, enlisting spokespeople, and so forth.

**“Collective efficacy” is the belief that the group/community is capable of accomplishing a task by working together.**



## VIETNAM: Meeting with the Community

Once the program team had assessed the community resources and health facilities and completed the nutritional baseline for the Poverty Alleviation and Nutrition Program (PANP), they held a series of community meetings to acknowledge the nutrition problem and its causes and solutions, including an initial feedback meeting with the Village Health Committee and Health Volunteers. Program managers strived to have a wide participation at these meetings, drawing from a cross-section of the community, including organized community groups such as the Women's Union and the Farmer's Union, along with the broader community. The purposes of the meeting were to:

- Explain the definition of malnutrition.
- Report the results of the community's nutrition survey of young children.
- Identify causes of malnutrition in the community.
- Review the goal and objectives for a nutrition program.

Project staff also stated the goal of PANP and invited interested community members to work together in addressing the problem of malnutrition in their communities.

*Save the Children Federation (US), Vietnam field office*

- Advocating the importance of the CM health issue with local leaders, using data, studies, critical incidents (such as death or illness), and other means so that local leaders put the CM health issue on their agenda.
- Sharing comparative data with the entire community on the prevalence of the CM health issue in their own community relative to other communities to emphasize the need for action.

## Overcoming barriers and resistance to participation

Undoubtedly, it would be easier for your team to work only with those people who show up in response to a general announcement (“rounding up the usual suspects”), but this strategy may not be the wisest or most effective if you truly want to reach priority groups. There are many reasons people may not want or be able to participate in the community mobilization process. We

believe that people should be free to decide whether or not they want to participate. There are times, however, when people genuinely want to participate but are unable to because of certain barriers. Knowing about these barriers and devising ways to overcome them can yield obvious benefits. Among the most common barriers:

- Limited physical access to meeting sites.
- Cultural limits to mobility and participation (e.g., women in purdah, caste structures, age).
- Time constraints.
- Responsibilities such as caring for children and animals, jobs, and the like.

- Family members or others prohibiting an individual's participation; for example, husbands may initially object to their wives participating in meetings because they may not see the benefit, particularly if no tangible incentives are provided.
- Perception that the meeting is for others, particularly if the individual has never been invited to participate in community meetings or has been actively discouraged from doing so.
- Opportunity costs of participation; if I attend this meeting I will not be doing something else that may be more beneficial to me or my family.
- Low self-esteem; I wouldn't have anything to contribute.
- Lack of identification with other participants; my needs are different and they wouldn't understand.
- Fear of group processes, having to speak in front of a group.

The team needs to identify the barriers to participation and work with community members who would like to participate to develop strategies to overcome their reluctance. (For further details, see pages 74-77.) Often those most affected by the health problem that you are working on are experiencing the greatest number of barriers to participation.

### STEP 4: Develop a "core group" from the community.

When individuals and groups have expressed interest in participating in the program, you will need to begin to develop a "core group" or those individuals who will lead the effort on behalf of the community. (This "core group" or community team should not be confused with the "program team" described in chapter 1—the team of "outsiders" from your organization whose job is to assist and advise this community team as they actually carry out the mobilization effort.) Developing and then supporting this core group are two of your own team's most important jobs.

**There are times when people genuinely want to participate but are unable to because of certain barriers. Knowing about these barriers and devising ways to overcome them can yield obvious benefits.**

**Participation in supportive groups may reduce stress and even *prevent* some health problems by reducing feelings of social isolation and by increasing social connectedness.**

## **The power of groups**

One of the great advantages of CM is the ability to harness the power of group dynamics. The advantages here include:

- Collective action often creates more power to advocate for changes in policies, relationships, resource allocation, access, and so on.
- Collective action can help bring to life inactive or ignored policies, procedures, and systems that are supportive of healthy communities.
- Combined resources can be stronger and more effective than uncoordinated individual resources.
- Collective action builds community members' awareness that they are not alone in their concern about and experience with the CM health issue.
- Participation in supportive groups may reduce stress and even *prevent* some health problems by reducing feelings of social isolation and by increasing social connectedness—factors that are believed to contribute to a strengthened immune system.
- Group experiences can create conditions for new leaders to emerge and for leaders and other group members to practice new skills.
- Individual members' skills can be complemented and enhanced by the skills and abilities of other group members (team work).
- Working with existing groups may strengthen their capacity to effectively address health issues.
- Newly established groups may evolve into local organizations or institutions that continue to work on the health issue or similar issues.



## An old group or a new group?

An important decision you may have to make at this stage is whether or not to work with an already existing core group or to form a new one. The BASICS project has had considerable experience with pre-existing groups and has learned some important lessons along the way (Green, 1998). The advantages and disadvantages are summarized below for your consideration.

The *advantages* of using existing groups include:

- Avoidance of delays in start-up. Extra time is not needed to organize new groups and give members time to become acquainted.
- Group cohesion. In existing groups the group dynamics have already been worked out. The group is usually stable and cohesive and can turn its attention to new topics.
- Trust. Over the course of years of working together, group members develop a common bond and learn to trust each other. This trusting relationship enables them to have a more open discussion about the realities of their lives.
- Altruism. Group members have demonstrated their interest in giving support to others.

Using existing groups also has certain *disadvantages*:

- Inflexibility. Groups may not be open to taking on new issues or different approaches.
- Dependence on incentives. Groups that were formed to receive some tangible benefit, such as food supplements, may not be motivated to attend group meetings when concrete incentives are not provided.
- Dysfunctional structure. Some groups may be structured in ways that discourage the active participation of all group members and that restrain members from divulging personal information.
- Unequal structures. The existing structure of a group may perpetuate inequities. When minority subgroups are excluded from participation in existing



groups, for example, their issues are not included on the community agenda and their needs remain unarticulated and unmet.

- The same old solutions. Existing groups may have fallen into patterns that discourage new ways of thinking and problem solving. The group arrives at the same solutions in the same way; when these solutions are not effective, the group is unable to generate new ideas. Changing the dynamics of group composition may help the group get out of the rut.

### Strategies for identifying and recruiting core group members

If you decide against using a pre-existing group or no appropriate group is available, then you will need to devise a strategy for identifying possible group members. The BASICS child survival project has also had experience in this area and has found success with the following strategies (Green):

- **Self-selection.** Ask people to divide into small groups, based on their personal preferences. For instance, the Child Health Institute in Haiti set up women's groups by asking one mother to choose one friend; the two women then chose a third, the three chose a fourth, and so forth (Storms, 1998). Women who know and trust each other may be more comfortable participating in group discussions and more willing to provide assistance to other members. On the other hand, cliques can develop and some community members may feel excluded and rejected. When the topic is highly personal—for example reproductive health—some members may prefer the anonymity of a group composed of relative strangers, if this is possible.
- **Common characteristics.** Recommend group participation to women receiving prenatal care at a health center. Organizing pregnant women into groups provides them with much-needed social support during pregnancy, delivery, and infancy. Having children of the same age group could facilitate education regarding the nutritional needs of children of various ages. Mothers with children of the same age serve as an important reference group as mothers adapt to children's different developmental stages.



- **Recruitment by volunteer leaders.** Identify volunteer leaders and ask them to form groups. Volunteer leaders can inspire people to join their groups. These groups are likely to be based in a small geographic area. A study in Honduras found that most volunteer breastfeeding advocates had contact with women who lived within a three-mile radius of their home (Rivera et al., 1993).
- **Nominations by community leaders.** Ask community leaders to suggest candidates for core group membership. This approach may be subject to favoritism and thus not assist women most in need of support groups. To nullify the favoritism factor, the CHPS program in Ghana has established a policy that nominees of community leaders must receive approval at a general community meeting or “durbar” (Fiagbey et al., 2000).
- **Public promotion.** Hold a public event and recruit group members from among the attendees. This strategy opens up group membership to a diverse audience, but finding common ground may be more difficult in such a diverse group.

Each of these strategies has its advantages and disadvantages. Group dynamics and cohesion are dependent on group composition. Groups that have great diversity of age, education, income, social status, and motivation have more difficulties than groups which are homogenous (Hyma and Nyamwange, 1993).

## Developing the core group

Once you have identified your core group, you will need to develop them into an effective team. On this subject, we can learn a lot from the work of the organization development and leadership fields about the stages of group formation and development. Let’s look at some of this important work and see how it relates to your role in developing your core group.





## Groups That Work

The World Bank has identified five characteristics of successful community groups:

1. The group must address a felt need and a common interest.
2. The benefits to individuals of participating in the group must outweigh the costs.
3. The group should be embedded in the existing social organization.
4. The group must have the capacity, leadership, knowledge, and skill to manage the task.
5. The group must own and enforce its own rules and regulations.

*Designing Community Based Development*, World Bank, 1999.

## The Tuckman Model of group development

Your group may want to think about the general stages which the literature says most groups go through as part of their development. The Tuckman Model of group development (1965) was based on Maslow's hierarchy of needs and designed as part of research which examined more than fifty studies of group organization. The original model presents four stages of group development: forming, storming, norming, and performing. A fifth stage, adjourning, was later added by Tuckman and Jensen (1977). A brief description of each stage is presented below (Kormanski, 1985):

**Forming.** This stage orients the group members to the group goals and procedures. Group members become more aware of the issues and begin to establish working relationships. During this stage, dependence (What can I do? How can I get the support I need?) is of primary concern. (Typically, the "forming" stage of group development occurs in the Organize the Community for Action and Explore the Health Issue and Set Priorities phases of the CAC.)

**Storming.** When orientation and dependency issues are resolved, the group moves on to define tasks and assign responsibilities. This process can create conflict and, at times, hostile relationships. Group members may resist or challenge group leadership. If conflict is suppressed, group members may become resentful; if conflict is allowed to exceed acceptable limits, group members may become tense and anxious. Some conflict is healthy for the group and helps the group to move forward. (The "storming" stage often occurs at the end of the Explore the Health Issue and Set Priorities stage and/or during the Plan Together phase of the CAC.)

**Norming.** The group becomes cohesive and cooperative. Group members communicate, share information and express their opinions. Group unity develops around achieving the CM goal. (The "norming" stage often occurs at the end of the Plan Together phase of the CAC when plans are being finalized and coordination mechanisms put into place.)



*Performing.* The group becomes productive. Members emphasize problem solving, meshing of functional roles, and interdependence. Members are simultaneously independent and dependent. (The “performing” stage often occurs during the Act Together and Evaluate Together phases of the CAC.)

*Adjourning.* This is the planned or unplanned termination of the group, its tasks and relationships. Planned adjournments involve acknowledging participants for their achievements and allowing people to say goodbye to the group. (“Adjournment” may occur at the end of the Evaluate Together phase of the CAC. At this point, group members may renew their commitment to the same health issue and determine whether they would like to maintain the same structure, roles and responsibilities, and composition or change the make-up of the group.)

**Leaders need to be aware of the different stages of group development, a group’s ability to do a task, and a group’s willingness and motivation to do a task.**

## **The role of leaders and external facilitators in group development**

An important aspect of the group development process is the role the leader or leaders decide to play. Different styles of leadership may be appropriate for different groups or even for the same group at different stages in its development.

Hersey and Blanchard developed a theory of Situational Leadership™ that complements Tuckman’s work (Kormanski, 1985). This theory states that leaders need to be aware of the different stages of group development, a group’s ability to do a task, and a group’s willingness and motivation to do a task. The leader should then tailor his/her leadership style to the particular needs of the group as it develops.

Hersey and Blanchard described four specific styles a leader might use in working with a group over an extended period: *Telling, Selling, Participating, and Delegating*. As the names suggest, the style usually evolves from directive to increasingly non-directive.

**Your team may want to think about and discuss appropriate leadership styles. You may use role plays, stories or real experience with groups to try out various leadership styles.**

There are many other perspectives on leadership styles that are helpful to know about, such as *Training for Transformation's* "authoritarian leadership" in survival situations, "consultative leadership" to build security, and "enabling leadership" to foster participation (Hope and Timmel, 1986). The list of resources at the end of this chapter mentions several other sources of information on leadership.

Your team may want to think about and discuss appropriate leadership styles. You may use role plays, stories, or real experience with groups to try out various leadership styles. It is helpful to observe different effective leaders and analyze their styles to determine what it is about their style that makes them effective in the settings in which they live and work. Are they using a mix of styles effectively? Have they found a group that naturally fits their preferred leadership style? Which leadership styles fit more naturally within the cultural setting in which these leaders work?

If you find that your team does not possess the organizational development and leadership skills to develop and work with groups, you may want to consider recruiting team members who do have this expertise.

### **Core group norms**

Part of the process of developing the core group includes establishing norms for working together. Below are some questions your team and the group members may want to discuss.



- Do they want to elect official leaders of the group?
- How will they assign roles and responsibilities?
- How will they communicate with each other? How often will they meet?
- What role do core group members want to play in relation to your program team? Groups with strong leaders may opt to have their leaders work with your team to develop their facilitation and leadership skills; other groups may initially rely on your team to facilitate the process.



- What norms do participants want to set for the group (e.g., confidentiality, be on time, listen to others, ask questions when you don't understand something)?
- How do members of the core group want to document the process and outcomes of their meetings and activities?

## Documenting core group and other meetings

There may be times when communities will not want to record their meetings, particularly if they do not trust how the information will be used or they are afraid the information could be misconstrued or used against them. For example, one community participating in the Warmi project did not want its discussions about family planning included in the notebook that recorded all of their meeting proceedings because they were afraid that others in and outside of the community would learn of their interest in these services. When program staff spoke with women's group members about the advantages of having the meetings documented, the women agreed on the condition that the notebook remain with them in their community and that they control it. Program staff agreed to this and the meeting proceedings continued to be documented.

In some settings, people do not traditionally document history through writing but may recount history orally through stories, songs, or other means. If writing is not something that comes easily to the community, there are other ways to document meetings, including tape recording, video, drawings, and other means. Helping program staff and participants learn to use a tape recorder, if one is available and practical, may help to facilitate documenting community mobilization and capacity building. The tapes can later be transcribed if necessary.

## Assessing and monitoring core group capacity

By now, it is clear that organizing and strengthening groups is an ongoing, dynamic process that you will need to address, not only during the Organize the Community for Action phase of the community mobilization process, but

throughout the community action cycle. In chapter 1 we discussed the importance of building community capacity and competency as one of the key outcomes of the community mobilization process. In this section, we will look at some measures of community capacity that you may want to monitor throughout the life of the program. If a group is newly established, the CM team will need to assess its potential capacity in light of the individual members' skills, abilities, and experience. As the group matures, it will be important to assess interactions and synergies within the group.

Suggested indicators for assessing a group's capacity for collective action include<sup>2</sup>:

- Increased access to resources.
- Increased collective bargaining power.
- Improved status, self-esteem, and cultural identity.
- The ability to reflect critically and solve problems.
- The ability to make choices.
- Recognition and response of people's demand by officials.
- Self-discipline and the ability to work with others.

It is important for groups to be able to assess their own progress over time. In general, discussion is usually richer when members first assess the group's capacity individually and then share their observations with the others in the group. It will be helpful for your program team or others outside of the core group to also observe the group's progress and provide feedback to the members. Save the Children's experience using self-assessment tools indicates that community groups (particularly relatively newly formed groups) may overrate or underrate their performance during the first year or two as they are learning to use the tools and are becoming more experienced with group work. As time goes on, they become more realistic in their assessments and can provide more specific

<sup>2</sup>Kindervatter, S. (1979). *Nonformal education as an empowering process: case studies from Indonesia and Thailand*. Amherst, MA: Center for International Education, University of Massachusetts.



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examples to back up their ratings. Tools that provide detailed descriptions for each level of performance tend to be more helpful than scales that simply ask the group members to rank their performance on a numerical scale. An example, the “Community Assessment Scale,” is presented as Useful Tool III. Communities use this scale to rate their progress every year.

Now that you have selected and begun to develop your core group, you are ready to work with them to jointly explore the health issue and set priorities for action, the two tasks covered in the next chapter.



**You will probably not be able (or want) to build capacity in every area, but you will need to select those indicators that are the most important to the group and your team.**

# Useful Tools

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## 1. Checklist for Community Organizing (Step 1, page 62)

Here is a list of questions to consider as you think about community organizing:



1. How has the community organized collective action in the past?
2. What is the main purpose of the community organizing phase for this program? (It may be helpful here to refer to the underlying themes or causes you identified in chapter 1.)
3. What are the possible benefits and consequences of working within the traditional structures? Can the underlying themes be addressed by working through these structures or do you need to think of alternatives?
4. What is the overall approach that you have decided to adopt for this program (problem-posing, strength-based, mixed, top-down or bottom-up)?
5. How will this approach be applied during the community organizing phase?
6. What is your team's role in the community organization process (direct implementation, training and providing technical assistance to community organizers, other)?



7. How do you plan to orient the general community to the CM program?
8. Who do you want to know about the program?
9. Which are the individuals, groups, and organizations you most want to reach and should invite to participate in the community mobilization process? Why?
10. Who will organize the general community orientation process?
11. How will organizers orient the general community about the program? (Consider strategies, methods/media, timing, and other issues.)

## II. Planning Checklist for a Community Meeting (Step 1, pages 63-65)

When planning a meeting and inviting participants, it is important to consider the following:

- **Participants:** How many participants are expected? Who will they be? (Consider total number, ratio of men to women, language(s) they speak, level of education, prior experience working in groups in general and working together in this group, social status/relationships, age, relationship to the issue.)
- **When:** The time, date, and length of the meeting should be convenient for the invitees. This point may seem obvious, but many teams continue to schedule meetings at times that are convenient for them but not for community members, which can limit participation. Additionally, community members should be invited with ample time before the meeting so they can plan to attend.
- **Where:** In some cases, there is little choice of venue as there are a limited number of community meeting places. When choice exists, the team should



consider who “owns” the space, physical accommodation (e.g., too big or too small? Too hot or cold?), whether it is accessible, whether weather or other conditions would affect the adequacy of the space, and related factors.

- **Agenda:** What are the objectives of the meeting? Which topics will be covered? In which sequence will topics be introduced? How much time will be dedicated to each topic? Is the time allocated sufficient and in line with meeting priorities and objectives?
- **Speakers/facilitators:** Who will run the meeting? Who will be asked to prepare and/or present information for the meeting?
- **Methodology/tools/techniques:** How will participation be encouraged and supported?
- **Documentation of meeting process and outcomes:** It is helpful to document what happens during meetings for many reasons, including:
  - To help participants and others learn from experience.
  - To orient new participants on what has happened in the past.
  - To resolve disputes or misunderstandings about decisions or actions.
  - To serve as a resource to evaluate programs.
- **Materials needed:** The materials needed will depend on the methods that will be used. Many facilitators ensure that paper, markers and tape (or other ways to hang up paper such as nails) are available. Additionally, you will need to review each session of the agenda to determine whether other materials need to be prepared.





### III. Sample Community Assessment Scale (Save the Children, 1988)

#### (Step 4, pages 81-83)

This diagnostic tool will help identify a community's present condition in relation to a desired condition. In between the two conditions, the core group and/or a broader community team and the program team plots progress towards a stated targeted objective.

#### How to use this tool

Once a year the program team meets with the core group and/or broader community to review the community's progress in building their capacity in participation and management. The tool presents seven assessment criteria (described on the following two pages) and asks participants to select the level that best describes their community's current abilities and practice. Participants are asked to provide concrete examples to support their estimation of their capacity. Once they have agreed on the level that best describes them at that time, they enter their score (1-5) for the year at the bottom of the page in the space corresponding to the year in which they are conducting the review. When they have rated themselves on all seven criteria, they add up the scores for an annual total. They can compare their scores from year to year to judge their progress.

While a quantitative score may be useful in comparing the relative abilities of a number of communities, the greatest value lies in the discussion leading up to the scores. It is important to note that in the first year communities may be very optimistic and overrate their performance. Then they are faced with the challenges of working together the second year and they tend to underrate their performance. Only by the third year will they have developed a more objective, realistic view. This tendency is particularly true for groups that have not worked much together in the past.

As community members discuss their current status, the program team should

facilitate a discussion to identify ways in which community members would like to improve on their performance during the coming year. Participants can use this time to learn from their experience and set new goals and/or objectives.

It is helpful to record the group's conversations (using audiotape, video, and/or in writing) so that this self-reflection can be incorporated into the community's history.

### Community management and participation

The chart beginning on page 90 presents seven criteria a community can use to measure its progress in managing a mobilization effort and the degree of community participation. These seven criteria are briefly described below:

- 1. Needs Assessment:** This category measures the community's planning skills and specifically their experience and involvement in goal setting and problem solving. It also measures their diagnostic skills, particularly the degree of understanding of cause-effect relationships (i.e., the linkage between poor water and disease or income shortages and seasonal agriculture).
- 2. Consciousness:** This category describes the community's willingness to effect change. It measures their willingness to plan for the future, particularly beyond their immediate, cyclical or seasonal needs and also relates to a group's receptivity to ideas, opinions, and critiques from the outside.
- 3. Programmatic Involvement:** This category describes how the community is involved in development activities. It focuses on the community's role in and degree of responsibility for project administration, maintenance, and evaluation. Over time it tracks the community's decreasing reliance on external assistance in key areas of program and project management. (Dependence on financial resources is covered in Section 6 on the next page.)



- 4. Organization:** This component describes the structures for decision-making and the mechanisms for articulating community and individual needs and preferences. Structures/mechanisms may be formal or informal, hierarchical or participatory, legally recognized with explicit operating policies and procedures or otherwise. They may be organized by project, interest group, community, impact area, or region.
- 5. Participation:** This category is defined by two dimensions. The first describes who in the community is actively taking part in and sharing in development activities. It measures the degree to which targeted groups, including the disadvantaged and poorer strata of the community, women, children, and youth, are meaningfully brought into the decision-making process related to project planning, implementation, and evaluation. The second dimension of this component measures the distribution of benefits among individuals and groups, especially those with limited means and opportunities to promote their own interests.
- 6. Financial Management Capacity:** This category is a composite of three related factors measuring the community's desire and ability to contribute significant resources to their own development. In the first instance it measures the level of community cash and in-kind investment. Secondly, it assesses the local group's (i.e., committee's or council's) credibility in the opinion of the community in managing these and other funds. Finally, this category measures the local group's skill level in managing funds under their control.
- 7. Linkages:** This category measures the mobilization of resources to support the community's development priorities and includes measuring the increasing utilization of internal (community level) resources. It also measures the community's awareness of external resources/opportunities and their ability to obtain these resources/opportunities ( i.e., credit, skills training, extension services) on favorable terms from a system that has by and large ignored them.



**COMMUNITY MANAGEMENT AND PARTICIPATION: Seven Assessment Criteria**

**Community: District/Province/Region:**

Criterion	Level 1	Level 2	Level 3	Level 4	Level 5
<b>1) NEEDS ASSESSMENT/ Diagnosis Skills</b>	The core group/ community is largely unaware of its own problems, their causes and effects. There is little experience in problem solving; little vision of the possibilities the future holds.	There are general discussions of community needs and problems, with some random attempts at problem solving. Field staff and extension agents are the dominant actors in planning, evaluation and project management. There is still a relatively low degree of understanding of cause-effect relationships.	The community is assuming an increasing role in identifying projects to meet priority needs, along with local resources. Cause-effect relationships are addressed clearly most of the time; the linkage between poor water and disease, income shortage and seasonal agriculture, for example.	There is broad-based participation in the needs assessment and resource allocation process, with the program team facilitating. Complex problems are identified and addressed in multiple ways, as the community moves from "project" to "program" implementation. Specialized community skills in the areas of planning, monitoring and evaluation are being developed and practiced.	Fully representative community groups demonstrate a consistent ability to identify and prioritize problems independently. They are also adept at explaining the causes and effects of these problems and utilize a collective, participatory approach rather than an individualistic one. They assume a leading role in planning, evaluation, resource identification, and project implementation.

**Score (1-5) for this indicator: YEAR 1**

**YEAR 2**

**YEAR 3**

**YEAR 4**

**YEAR 5**




Organize the Community for Action



Criterion	Level 1	Level 2	Level 3	Level 4	Level 5
<b>2) CONSCIOUSNESS (Understanding/Comprehension)</b>	Community members are highly fatalistic; they show an aversion to change or risk-taking and lead a hand-to-mouth existence. There is a rigid adherence to past ways, with little desire for change. People exhibit a pronounced dependency/welfare attitude. The elite often believe they must give up something if the poor are to benefit; people “look out for themselves.” There is a rigid social hierarchy. There is an acceptance of the notion that the strong survive; the weak perish.	Community members remain suspicious of collective efforts and skeptical about the effectiveness of external assistance. Traditional leadership structures are followed even if it is recognized that development will not be served. Youth groups and women’s groups may show some initial receptivity to discussions and innovative ideas.	A widening base of community members recognizes that they must try, in small-scale ways, to effect change, for the betterment of the community. There is a willingness to try collective action if convinced of a potential success; a leader or a small elite group still makes the decision to go ahead. The risks taken are still very limited and do not infringe on traditional modes of security. Innovation may be introduced through a handful of “forward-looking” individuals.	Community members are convinced that they can effect change, based on their successful efforts. There is also a belief in the value of collective action. The community is open to trying innovating programming methods with a higher risk of failure. The wealthy and elite recognize that an improved quality of life for the poor benefits all. Women and youth participate in decision-making openly. There is still a level of dependency on the program team for overall direction, resources and technical advice.	Community members believe strongly in their ability to effect change. They are open to innovation and plan for the future, in some instances deferring immediate benefits. There is little competition between the elite and the poor for resources; rather, there is a sense of cooperation and a belief in the rights of all groups to participate. They express a feeling of little need for continued external assistance.

Score (1-5) for this indicator: YEAR 1

YEAR 2

YEAR 3

YEAR 4

YEAR 5




**COMMUNITY MANAGEMENT AND PARTICIPATION: Seven Assessment Criteria**

Community: *District/Province/Region:*

Criterion	Level 1	Level 2	Level 3	Level 4	Level 5
<b>3) PROGRAMMATIC INVOLVEMENT</b>	There is a passive attitude towards community improvement, coupled with few technical and organizational skills within the community. Random discussions about community problems may occur, but these are seldom followed by any action. Often, people are unaware of the services and resources available to them.	There is an evolving demand for services and resources, often from government groups coupled with an awareness of their absence within the community. Often the poorest members of the community are “volunteered” for labor and projects developed by external assistance groups. Leaders become involved if they sense they will benefit and will subsequently try to channel the project direction to their advantage.	The base of participation (both in numbers and demographic composition) in projects is widening as community members take a firmer interest in the potential program benefits. Women and youth may have some share of these benefits, but little overall voice in decision-making. Community members begin to formulate project goals, timeframe, and action plans. On-site supervision and guidance from the program team is often required.	Community members begin to take an active role in the conceptual as well as the action aspects of development activities. Committees are able to follow through on more than 10 projects in a given year. Community members are beginning to assume responsibility for management functions once held by staff. Basic evaluation systems are utilized. Community members have specialized, technical skills.	A broad spectrum of community groups demonstrate a willingness and ability to be involved in all aspects of development programming. This involvement includes a demonstrated ability to identify objectives, resources, indicators and sequential steps to achieve objectives; an ability to select workers/participants for projects and to allocate responsibility; through follow-up, an ability to evaluate performance on the basis of indicators and other project data.

**Score (1-5) for this indicator: YEAR 1**

**YEAR 2**

**YEAR 3**

**YEAR 4**

**YEAR 5**






Criterion	Level 1	Level 2	Level 3	Level 4	Level 5
<b>4) ORGANIZATION</b>	The community's organizational structures are dominated by a small elite, who act most often in their own self-interests. There are often competing leadership factions, or a structure imposed by external sources. These structures are ineffective and largely unmotivated to effect change within the community. There are no broad-based representative groups capable of carrying out self-help activities.	While the community's organizational structures are still dominated by a small elite, there is some evidence of emerging, informal structures. Leadership patterns within these structures are somewhat transient or unrecognized by the public at large. Special interest groups may emerge, centered on a particular issue or need. Meetings tend to be sporadic, overtime, or held together by program team involvement.	A formal grouping has emerged, often combining elements of the traditional and newer structures. Leadership and decision-making structures have been defined. Regular meetings are held, focusing primarily on problems, issues and initial projects. Program team plays a key role in organizing and facilitating these meetings.	Organizational structures have evolved into a network of diversified and representative sub-committees. Frequently, these subcommittees are specialized into such areas as pre-cooperatives, credit unions, health clubs and farm clubs. Linkages and communication between the main committee and sub-committee are effectively established. The main committee shows a growing level of efficiency in program management and running its own meetings.	Community organizational structures reflect the evolution of a broad-based, actively involved, representative leadership structure and viable support networks. Organizational structures are composed of diverse interest groups and demonstrate an ability to administer funds, collect debts and implement projects effectively. Information sharing is open and there is a low level of self-interest in decision-making. Many groups have a legal status and there is a large degree of inter-community and inter-group collaboration.

Score (1-5) for this indicator: YEAR 1

YEAR 2

YEAR 3

YEAR 4

YEAR 5




**COMMUNITY MANAGEMENT AND PARTICIPATION: Seven Assessment Criteria**

**Community: District/Province/Region:**

Criterion	Level 1	Level 2	Level 3	Level 4	Level 5
<b>5) PARTICIPATION</b>	There is little, if any, voluntary participation in any development efforts. Women and youth have no role in the decision-making process of the community. Benefits, if any, are channeled to a few elite members. Problems are addressed in an ad hoc manner. The community's focus is on personal survival.	Participation in community groups and activities is still very limited. There are some special work days organized for which significant numbers may turn out; but sustained involvement is unusual. Labor may be asked from the poor for community infrastructure programs of benefit to all. A few community members beyond the elite begin to benefit.	As the types of projects diversify, the base of participation and benefits begins to widen, both in terms of the composition of the groups and in numbers. Greater perseverance in implementing projects over a sustained timeframe (6-12 mos.) is recognizable, and systems to organize labor and resources begin to emerge. The community depends on the program team for overall organization and technical assistance. There is an interest in pilot projects and "models."	Participation begins to occur spontaneously, without a great deal of nudging and cajoling. Projects are conceptualized and designed independent of the program team. The degree of programming comprehensiveness builds, with more complex plans and management objectives. Equity of programming benefits is discussed openly at community meetings, as are the interests of various groups. Newer groups are willing to "take on" the establishment if need be.	There is a significant breadth of participation in the community development effort and an overall equity in the distribution of program benefits. Community groups demonstrate an understanding of the linkages between various problems and a comprehensive, integrated programming approach is utilized.

**Score (1-5) for this indicator: YEAR 1**

**YEAR 2**

**YEAR 3**

**YEAR 4**

**YEAR 5**








Criterion	Level 1	Level 2	Level 3	Level 4	Level 5
<b>6) FINANCIAL MANAGEMENT CAPACITY</b>	The community demonstrates very little desire to contribute resources to development. Labor, if it is donated, is usually mandated by the elite as an exercise of power. Loans, if they are distributed, are generally not repaid. There is very little evidence of savings or accrued assets.	A few individuals in the community, often "patrons," donate a significant asset (e.g. parcel of land, building materials) to a special project. A rudimentary revolving loan fund for project activities is established, but the community has little experience in managing it. Most materials are purchased by external organizations. Community contributions amount to less than 30% of the overall project budget.	Community contributions begin to escalate, particularly in the areas of labor, materials, and some land donations. Training in loan concepts and management has been initiated, and some initial loans distributed on the basis of need. Repayment rates not exceeding 70% are common. The community experiences an interest in overall resources allocation. Community contributions range up to 50% of the overall project budget.	The community begins to invest heavily in its own development, often with a 100% match to outside resources. Loan distribution begins on a larger scale, exceeding project grants in the overall picture of project assistance. Repayment rates are from 75-80%. Committees take responsibility for overall loan recovery with assistance from the program team.	The community's desire and ability to contribute significant resources to its development process is amply demonstrated. The community contributes labor, land, produce, materials, cash, and other resources willingly for its own development. The concept of loans is fully understood and the community is efficient at loan recovery. Community assets from loan recovery are fully utilized for new development efforts.

Score (1-5) for this indicator: **YEAR 1**

**YEAR 2**

**YEAR 3**

**YEAR 4**

**YEAR 5**




**COMMUNITY MANAGEMENT AND PARTICIPATION: Seven Assessment Criteria**

Community: *District/Province/Region:*

Criterion	Level 1	Level 2	Level 3	Level 4	Level 5
<b>7) LINKAGES</b>	The community is largely insular and unaware of external resources. It is content to sit by and wait for the government to do something.	The community is still largely passive, although a special delegation may approach a political figure or influential citizen for community assistance. Wealthier members may use special services from larger communities—health clinics, markets, newspapers, and shops, according to financial ability.	The community is aware of the need to build outside contacts. They are able to identify and approach some of these resources, requesting specific services and resources for the community, with mixed success.	The community becomes increasingly aware of the value of external services and resources. They are able to maintain their current linkages and identify others for exploration. Proposals presented to these resources are generally viable and well-received. The government and other funding agencies are aware of the community's accomplishments and needs.	The community exhibits a high degree of awareness of external resources/services and an ability to tap into them. The community demonstrates motivation and initiative in accessing and leveraging these resources for specific community needs. The community is well-perceived by governmental groups and other agencies, which respond to these requests favorably, on the whole.

Score (1-5) for this indicator: **YEAR 1**

**YEAR 2**

**YEAR 3**

**YEAR 4**

**YEAR 5**

**COMMUNITY MANAGEMENT AND PARTICIPATION: Seven Assessment Criteria**

ASSESSMENT CRITERIA	1	2	3	4	5	6	7	TOTAL
<b>YEAR 1</b>								
<b>YEAR 2</b>								
<b>YEAR 3</b>								
<b>YEAR 4</b>								
<b>YEAR 5</b>								



# Resources

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- Bhattacharyya, K. and J. Murray. (1999). *Participatory Community Planning for Child Health: Implementation Guidelines*. USAID/BASICS Project.
- Christian Reformed World Relief Committee. (1997). *Partnering to Build and Measure Organizational Capacity: Lessons from NGOs Around the World*. Grand Rapids, MI: Christian Reformed World Relief Committee.
- Fiagbey, E. et al. (2000). *CHPS Implementation Guide: Formation of Community Health Committees*. Baltimore: Johns Hopkins University Center for Communication Programs/Ghana.
- Goleman, D. (1998). "What Makes a Leader?" *Harvard Business Review*, November-December, pp. 93-102, (Reprint 98606).
- Green, C. (1998). *Mother Support Groups: A Review of Experience in Developing Countries*. USAID/BASICS Project.
- Heaney, C.A. and B.A. Israel. (1997). *Social Networks and Social Support in Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco: Jossey-Bass, pp. 179-205.
- Hope, A. and S. Timmel. (1986). *Training for Transformation, Book 3*. Gweru, Zimbabwe: Mambo Press, pp. 101-102.
- Hyma, B., and P. Nyamwange. (1993). "Women's role and participation in farm and community tree-growing activities in Kiambu District, Kenya." In J. Henshall Momsen and V. Kinnaird (eds.), *Different places, different voices: Gender and development in Africa, Asia and Latin America*. London: Routledge.
- Kindervatter, S. (1979). *Nonformal education as an empowering process: case studies from Indonesia and Thailand*. Amherst, MA: Center for International Education, University of Massachusetts.
- Kormanski, C. (1985). "A Situational Leadership™ Approach to Groups Using the Tuckman Model of Group Development." *Developing Human Resources*. San Diego, CA: University Associates, pp. 217-224.

- Leach, M. (1994). "Building Capacity Through Action Learning." *IDR Reports*, Vol. 10 (5): 1-29.
- MAP International. (1997). "Community Participation Assessment Tool." Presented at a Community Mobilization workshop sponsored by Johns Hopkins University Center for Communication Programs and Save the Children/US, Cochabamba, Bolivia.
- Minkler, M. (ed.). (1997). *Community Organizing and Community Building for Health*. New Jersey: Rutgers, The State University.
- Rivera, A., et al. (1993). *The Promotion of the Lactational Amenorrhea Method and Child Spacing through Breastfeeding Advocates*. Washington, DC: Georgetown University Institute for Reproductive Health.
- Rivera, F., and J. Ehrlich. (1995). *Community Organizing in a Diverse Society*. Boston: Allyn and Bacon.
- Rosenberg, J.E. and M.J. Joya de Suarez. (1996). *Community-based breastfeeding support: A guide for trainers and supervisors*. Washington, DC and San Diego, CA: Expanded Promotion of Breastfeeding Program, Wellstart International.
- Spencer, L.J. (1989). *Winning Through Participation Meeting the Challenge of Corporate Chance With the Technology of Participation*. Dubuque, IA: Kendall/Hunt Publishing Co.
- Storms, D. (1998). Personal communication on support groups as a health intervention reported in Green, C. P. (1998). *Mother Support Groups: A Review of Experience in Developing Countries*. USAID/BASICS Project.
- USAID. (1999). "HIV/AIDS: Care and Support Initiatives via Community Mobilization." *Displaced Children and Orphan Fund Synthesis Paper*. Washington, DC: USAID.
- World Bank. (1999). "Designing Community Based Development." *Environment Department Dissemination Note*, Number 17.



# Chapter 3

## Explore the Health Issue and Set Priorities

3

1. Decide the objectives for this phase
2. Explore the health issue with the core group
3. With the core group, explore the health issue in the broader community
4. Analyze the information
5. Set priorities for action



“We are not teachers or transferors of technology, but instead conveners, catalysts, and facilitators. We have to unlearn, and put our knowledge, ideas and categories in second place. Our role is to enable local people to do their own investigations, analysis, presentations, planning, action, to own the outcome, and to teach us, sharing their knowledge.”

Robert Chambers

In the last chapter on community organizing, we looked at how to identify and organize a core group of participants. Now it's time to begin an in-depth exploration of the issue or health focus of the community mobilization effort. This phase may be referred to by a number of names, such as a needs assessment, participatory research, the “discovery” phase, “autodiagnosis,” or others depending on the project team's approach and strategies.

### Participatory Exploration

External organizations often see this phase as a data collection exercise primarily meant to help them “design the intervention.” Many fail to recognize that this phase, particularly when done in a participatory manner with the community, *is* an intervention. It is part of an ongoing process that furthers community dialogue and builds awareness around the health issue. When carried out in partnership with community members, this exploratory phase can foster community ownership and create an impetus for change by bringing together and mobilizing key actors. The exploratory phase builds common understanding, skills, and relationships between individuals and groups who are affected by and/or care about the health issue. And it gives those who participate in the Plan Together phase important information on key subjects, including:

- The community's social and demographic characteristics.
- The community's morbidity rates and, in some cases, mortality rate estimates.
- The current health status related to the community mobilization health issue.
- People's current values, knowledge, attitudes, beliefs, and practices related to the health issue, such as care-seeking, utilization of health services, care provision, and home/community-based behaviors.



- The number of people directly and indirectly affected by this health issue.
- The groups most affected by this health issue, what they think and do about it, and how others perceive them.
- Traditional and cultural views on why this health condition exists.
- Available community resources.

**“Seek first to understand, then to be understood.”**

**—Stephen Covey**

This participatory exploration phase deepens critical reflection and dialogue around the health issue, which is particularly important when people may not perceive the health issue as a priority or when the topic, such as reproductive health, is rarely if ever discussed publicly or even privately.

All too often, programs and strategies are implemented based on external untested assumptions or on externally prescribed health behaviors without first understanding the individual, group, and community perceptions and underlying causes and influencing factors of the health issue. In keeping with Stephen Covey’s wise saying—“Seek first to understand, then to be understood”(1990)—the program team’s role in this phase is to ask questions to help the core group and other participants understand the current situation as it relates to the issue, to serve as resources to provide helpful information toward this end, and to *listen*.

Once this information has been collected (in steps 2 and 3 of this chapter), the program team and the core group can conduct an in-depth, participatory analysis (step 4) of what it means for and how it affects the intervention that will be planned in the next chapter. This analysis will help the team do the following:

- Determine the current health/social situation.
- Establish a quantitative and qualitative baseline.
- Generate community awareness, interest, and consensus.
- Garner support for the issue.
- Increase understanding of causes of the problem(s).
- Develop a common language to talk about the health issue.
- Increase community members’ skills in identifying problems and prioritizing them.

- Sensitize external team members to existing belief systems.
- Build program ownership and teamwork.
- Identify program participants in the mobilization process.
- Develop a base for program planning.
- Justify resource allocation/funding.
- Identify gaps and opportunities for improvement.

## STEP 1: Decide the objectives for this phase.

Prior to exploring the health issue with the core group, your team will need to determine the objectives of this exploration phase. It is not uncommon to have multiple objectives that correspond to the various actors and stakeholders interested in the project. For example, your objectives might be:

By the end of this exploration phase, participants will have:

- established quantitative and qualitative baselines to be able to measure change over the life of the project.
- raised community awareness of, interest in, and commitment to the health issue.
- increased core group members' capacity to conduct and use participatory research.

Other examples of capacity building objectives for this phase might be:

- Participants will be able to identify at least # sources of information on health status.
- Participants will be able to interpret data on health status in meaningful ways (e.g., note trends over time, compare their community status with other communities, relate changes in status to possible or probable causes).





- Participants will be able to discuss the health topic in a public forum.
- Participants will be able to identify appropriate methods to collect quantitative and qualitative data.
- Participants will demonstrate that they can collect information from others in the community.

Remember that your objectives should be directly related to the overall program goal. If that goal is “to reduce maternal mortality in participating communities,” then you will explore with the community maternal mortality and those factors which affect or influence maternal death. The area of investigation should be determined by the program goal. If you are entering a community without a predetermined goal, a health needs assessment will help to determine those areas of greater need as defined by health system and other relevant data, and as expressed by community members. The more focused the goal, the more likely it is that communities will be able to develop concrete objectives and an action plan to address the situation and to monitor and evaluate impact.

## STEP 2: Explore the health issue with the core group.

This exploration phase begins with an in-depth examination of the health issue with core group members to learn as much as possible about their current feelings, knowledge, practices, and beliefs related to the issue and their capacity to address their needs. This step is usually carried out in a session or series of sessions with the core group. How many sessions you dedicate to this internal exploration of the health issue will depend on:

- The level of trust and confidence that has been established in the group and with facilitators.

**The more focused the goal, the more likely it is that communities will be able to develop concrete objectives and an action plan to address the situation and to monitor and evaluate impact.**

3



- How narrowly or broadly focused your health issue is: with broader issues, there is often more technical content to discuss, so it may take longer.
- Time available: participants' availability to meet, donor constraints, team members' availability.
- Logistical concerns: geographic access, seasonal concerns (rains, planting, harvest), transport, other scheduled community activities.
- Who facilitates the process: if your program team is working with core group members to build their capacity, you may need more time to conduct training sessions and then have new facilitators conduct group sessions.
- The relative value of exploring the issue in several sessions over a period of time versus in one longer session: if participants feel the need to discuss the topic with their families, friends, or others before they set priorities, they may appreciate the chance to do so between sessions. Planning for at least two sessions is usually a good idea as it allows participants time to process what they have heard and experienced, and they may have new insights for the next meeting. This approach is very helpful for those people who need time to think about how they really feel before they can articulate their feelings.
- Attention spans, level of difficulty of processing information: people can get tired or preoccupied with the other things that they need to do.
- Whether you have achieved your objectives for this step. If not, will more time help? Were the objectives realistic? Is there a more effective approach you could use?

### Beginning the dialogue: sample questions for the core group

Once you have been able to bring the core group together, it's time to start learning what they know and how they feel about the health issue. The questions that are asked here (see below for examples) should be very open, and participants should be free to describe what they know and do without fear of being corrected. Leading this kind of session is often hard for facilitators who are new to this role, particularly for health workers who





have been trained in a more prescriptive approach to health education. But it is critical to establish a safe environment in which participants can express themselves freely and learn from each other. Facilitators and other project team members should be listening carefully to the words used, noting specific practices and, most importantly, identifying the reasons given for why these practices are used.

Before you start asking the questions, you will need to spend some time helping the group develop a common vocabulary to talk about the health issue. To be able to understand each other when they talk about a topic, participants need to use language that is understood by everyone. Health issues have their own local lexicons that all participants need to be familiar with. Some questions that a facilitator might use to help the core group establish a common vocabulary are:



- What are all the words we know that are used to refer to this health condition/problem?
- Are there other local words? What do they mean?
- What kinds of words do we use to describe this health condition?
- How many different terms are there? What do they mean? (For example, in some communities there may be many words for diarrhea, each describing a different consistency or color.)

If the CM goal is broad, such as reducing deaths of children under five years old, you may ask what are the conditions and illnesses that children die from and then use the questions above to elicit local terms for these conditions or circumstances (e.g., diarrhea, respiratory infections, accidents).

### A Need is Not Necessarily a Problem

It is important to remember that a need is not the same as a problem. A *need* is a lack of or deprivation of something that should normally be a part of the life of a person, group, or community. Other names for needs are aspirations, desires, dreams. *Problems*, on the other hand, are obstacles or barriers to satisfying a need or desire.

Take an example: The people in a neighborhood felt the *need* to apply hygienic and nutritional practices so that their children would grow up healthy, avoiding illness and death. But, to satisfy this need, they encountered two *problems*:

1. Many parents were unemployed so there were few resources to buy food and shoes for the children; nor could they afford to buy materials to build latrines. The need is healthy children but the problem is economic.
2. The fathers and the mothers cannot read pamphlets that have been distributed by health promoters. The need is healthy children; the problem is the parents' inability to access and use the information.

Another example: An autodiagnosis was carried out in a project that aimed to increase rural women's participation in community development. The women identified problems of health, education, and transport. They formed groups to discuss women's participation and the resolution of their problems. For a few months many women came to meetings organized by project promoters. Suddenly, they stopped coming to the meetings. When they were asked why they stopped coming, they responded: "Our husbands complained that we spend all this time discussing and don't resolve anything." They were then asked what they really wanted to do for the project and they answered, "We want sewing courses because we want to learn how to make clothing for our children."

Needs perceived by the community may be different from problems that are the focus of external projects. Technicians tend to see problems and ignore needs. If someone does not feel the need for something, not having it does not represent a problem for her/him. For example, for many people the fact that they cannot read does not present a problem when they don't feel the need to read. Similarly, if parents believe that their children are growing normally, they will not see the problem of malnutrition.

The diagnosis, then, should emphasize discovering the felt needs of the people. It is in the felt needs where energy and motivation reside.

*Bordenave, Juan Diaz. (1997). Unpublished document*

Finally, if the health issue is an intimate topic which participants may not feel comfortable discussing directly, you may want to help participants project their thoughts and feelings onto others. For example, you could ask: “Who knows of someone who has experienced this problem?” Or: “What do you think it would be like to experience this health condition? Why?” Picture cards, drawings, stories, songs, videos, puppet shows and other techniques based on real experiences can help participants express their thoughts and feelings about the topic in a safe and entertaining way. Don’t underestimate the importance of emotional identification and commitment to the health issue and to building a sense of community, support, and trust within the group. This is an important step! You can begin to see trust building when participants feel safe enough to share their own personal experiences, particularly when the topic is one that is not normally discussed in public.

Below you will find a series of questions that can be used to elicit important information from the core group. They are organized around the six key elements of this step: knowledge, feelings, attitudes, practices, beliefs, and facts about the core group itself.

### **Knowledge** questions:



- What is the problem/health condition called?
- What causes this problem or condition? Why does this problem occur?
- What prevents this problem?
- What cures the problem?
- How widespread is this problem?
- Where do you go if you need help with this problem?
- How many people die/get sick from this problem in your community?
- How many people in the community/region/country/world are directly affected by it?
- How many people have taken steps to prevent this health problem (if applicable)?
- How many people seek health care services when this problem occurs?



How many people do not utilize formal health services?  
How many people utilize traditional health services for this health problem?  
What happens if you don't treat the problem?



### Questions about *feelings*:

How do you think people with this health condition feel? Why?  
How would *you* feel if you had this condition?  
How do other people in the family feel about a family member with this condition?  
How do you think other people in the community feel about someone with this condition? Why?

### Questions about *attitudes*:

What has been your experience with this health issue?  
How do you feel about this problem/issue?  
How do you feel about others who are experiencing this problem?  
How does this problem affect you, your family, your community?  
How does it feel to be healthy?  
What does it mean to be healthy?  
What is a healthy person?  
What is a healthy family?  
What is a healthy community?  
How important is this issue to you? Why?  
Are you interested in working on this issue? Why?

### Questions about *practices*:

What do you do when this health problem/condition occurs? Why?  
What do you see others doing? Why do they do it?  
What are you/people in the community currently doing to prevent this





health problem from occurring? Why?  
Which of the practices that you/others do are beneficial? Successful?  
How do you know?  
Which of these practices are (can be) harmful? How do you know?  
How much agreement is there about these practices?  
What do you do to keep yourself healthy? What do you do to keep your family healthy?

#### Questions about *beliefs*:

What factors influence whether and how a person will be affected by this health issue/problem?  
What practices do you believe the community would approve of related to the health issue? Why?  
Which practices would be met with disapproval? Why?

#### Questions about the *core group* itself:

Have members of the core group worked together on any issue in the past?  
If yes, what was the result of their efforts? What did they learn through the experience?  
Who were the leaders? How did they lead the group?  
Has the core group worked on this particular issue in the past? If yes, what was their experience? What failures and successes did they have? Why?  
Who are the leaders now on this issue? What do they say? What do they want people to do?  
Which collective assets does the group have? (physical, financial, human, other resources, abilities, strengths)  
Do others outside the group recognize the group as an entity within the community?  
Does the core group have any affiliations with other organizations or groups related to this issue? If yes, what role does the core group play in these affiliations?



What do core group members want their group to be able to do in the future? Is there a common vision, mission, and/or objective that its members can articulate?

What role does the core group want to play in collecting and analyzing baseline data and raising community awareness about the issue? What skills does the group want to strengthen to play this role?

In addition to learning about specific beliefs and practices, it is helpful to try to understand these beliefs and practices from a systems perspective. Often practices and beliefs are tied together in a complex web of interdependent relationships. For example, many cultures base their medicine on beliefs about trying to maintain an appropriate balance between hot and cold elements or higher and lower elements that may be influenced by natural or supernatural forces. Ethnophysiology aims to understand how people view their bodily functions, which elements affect them, and how. It is helpful not only to identify the practice and why people use it, but also to identify the relationships between the “whys”. Body mapping, where people draw pictures to demonstrate how they view their internal organs and systems, is a particularly useful technique to develop this understanding.

You may also want to give some thought to the sequence in which you ask these and other questions of the core group (and, later, members of the community). Usually it is more comfortable for participants when you start with topics that people are more accustomed to speaking about publicly before you introduce more intimate topics. Based on the experiential learning cycle, we also know that adults usually learn better when they start with specific experiences, reflect on them, generalize the learning, and then apply what they have learned. Applying this sequence to exploration sessions, it is usually better to start with questions about actual experiences (personal or observed) and then move on to the more abstract questions aimed at generalization. Often when you begin with abstract questions, participants’ responses remain abstract and removed and can lose personal relevance for the group.

**In addition to learning about specific beliefs and practices, it is helpful to try to understand these beliefs and practices from a systems perspective. Often, practices and beliefs are tied together in a complex web of interdependent relationships.**

3



**In many cases, the program will need to extend beyond the core group to mobilize the broader community.**

### STEP 3: With the core group, explore the health issue in the broader community.

The previous step explored the core group members' knowledge, feelings, beliefs, and practices related to the health issue. That step also aimed to build trust, confidence, and cohesion in the group. Some programs limit their activities during the exploration phase to this core group process and then proceed with the core group directly to the Plan Together phase. This approach may be appropriate when the core group consists of the entire community or when improvements in health status are sought only for group members, and group members have the decision-making authority, ability, and resources to make improvements in their health themselves.

But often this is not the case when you are working with people who have limited access to information, services, time, and other resources. In many cases—especially when there are diverse perspectives and/or when collective action beyond the members of the core group is necessary to improve access, quality, or availability of the means to better health—the program will need to extend beyond the core group to mobilize the broader community.

Just as the program team planned for the core group exploration process, now the core group (with assistance from the program team) needs to plan for the exploration process in the broader community. One of the first issues to decide is the extent to which the core group will be involved in developing and/or participating in this exploration process. Ideally, core group members would act on their own or as partners with the program team in designing this process, but in reality they often don't; more often they participate in the actual conduct of the various exploratory exercises and studies, but using an approach predetermined by the program team to do so.





All other things being equal, the more involved the core group is in exploring what the broader community does, feels, and thinks about the issue the better. But “all other things” are sometimes not equal. Here are some criteria to keep in mind as you make your decision about this important question:

- The core group’s previous experience in developing and conducting an assessment or baseline study.
- The core group members’ interest in learning how to design community assessments.
- Time and resources available.
- Weighing overall program needs with community needs and desires.

Regarding the last point above, when demonstration projects are the subject of donor, development and scientific community interest, it may be wise to mix relatively “objective” baseline studies done by external research and evaluation organizations with participatory community research processes. In fact, if you have the resources to hire an external agent to conduct a baseline assessment, it is important to feed these results back to the community as input for their discussions on priority setting.

Whoever ends up being involved in this exercise (hereafter referred to as the “information gatherers”), this group will need to make three important decisions about this activity:

1. **Objectives:** What is it that they want to learn about this health issue in the broader community and why? What are their other objectives (raise community awareness, broaden community participation, involve local leaders, other)?
2. **Methods:** How will they gather and use this information? Does it already exist or do they need to collect it? Who will be responsible for organizing, coordinating, collecting, consolidating, and analyzing the information?





3. **Resources:** Which human, financial, and material resources will they need to carry out the assessment? What resources do they have now? What resources will they need to get? How will they get them? Are there specialists in monitoring and evaluation, epidemiology, social science, anthropology, sociology, and other related disciplines that can help them?

### Gathering information

In most situations, gathering information is a two-step process. In the first step, you, as information gatherers, should track down information or data that has already been collected about the community (in previous surveys, research studies, national demographic studies, situational analysis, and so forth). You will then need to analyze this information in light of your objectives and identify what additional information you will need in order to design your intervention.

Now you are ready for the second step of this process which is to supplement the information you found in the first step with information you will now have to go out and collect. To begin this process, you will need to familiarize yourself with and ultimately select a variety of tools for information gathering. A number of the most common tools used in community mobilization projects are described in Useful Tool III at the end of the chapter. Your choice of tools will depend on your project's objectives, your team's skill, and the dynamics and characteristics of the community in which you are working. We recommend a combination of both quantitative and qualitative methods to best support community learning.



When you build a house, you use tools and techniques to help you perform specific tasks in a particular sequence. The best tool for a job, used in the right way at the right time, makes the job easier and results in a strong house with less effort than had you tried to construct it without the tools. The same is true of using the right tools and techniques at the right time to gather information. In the case of information gathering, for example, a tool such as



an interview may provide specific information, but if you were to use a sociodrama for people to act out what they do, you might see differences between what they say they do (in an interview) and what they act out in the sociodrama. Participants will need to pay attention to the various factors that may influence results (such as social norms, self-awareness, wanting to please the information gatherers) and should consider using a variety of appropriate tools to gather information.



When working with the core group/information gatherers to select appropriate tools, techniques, and methods, the program team should consider the following questions:

- Will the tool gather the specific information desired? What do people drink or eat when they have diarrhea, for example, or what do women do to take care of themselves when they are pregnant and why do they do these things? Some tools are more appropriate for gathering information on knowledge (e.g., interviews, surveys); some work better for learning about practices (sociodramas, videos, observation); others may help to reveal beliefs and feelings (storytelling, songs, poems, drawings); others will illustrate relationships (Venn diagrams, drawings,) or processes (flowcharts, stories, histories, timelines).
- Is the tool or technique culturally acceptable? Will participants feel comfortable with the tool or will the tool inhibit participation and response? Will “gatekeepers” object to the use of this tool (e.g., parents when the respondents are children)?
- Is the tool or technique used with individuals or groups and how will this influence responses for your particular issue? Should the tool be used with groups of women or men (or other characteristics that may influence its effectiveness) or can it be used with mixed groups?
- Are there underlying themes or process outcomes that you would like to address while gathering information that would be better addressed by some tools and techniques over others? If improving women’s status has been identified as an important theme, for



## BANGLADESH: Whose Community Are We Mobilizing?

Community workers carrying out a participatory rural assessment (PRA) are encouraged to recognize that the people whom we normally meet and speak to in a village form only a small part of the population. Most often we speak to male elders. Young men are often left out, as are children. If we speak to the “women’s group,” we often fail to recognize that these women tend to be the wives of better-off, more influential men in the community. The single mothers, the divorcees, the poorer women tend to be excluded from such groups on the basis of economic well-being, access, standing in the community, educational levels, or age. PRA’s can teach community workers to recognize that each group of people in a community has its own interests, perspectives, and needs. One group alone cannot speak for the others. No one group necessarily has “better” information than the next. The PRA will also work to uncover local knowledge, strategies, and responses to addressing health and social problems. The community worker carrying out the PRA can grow to recognize that the exercise is rather like filling in a jigsaw puzzle. Unless we take the trouble to talk to different members that make up a community, we don’t complete the puzzle of community knowledge and experience.

Those community workers carrying out a PRA are able to learn that each group has its own concerns, experience, and skills, and that they should be heard. Paying close attention to those groups who may be most at risk, marginalized, and with little voice will provide a clearer picture of the community and those influences on community health and well-being.

*Adapted from Welbourn, 1994.*

example, yet men ask the questions in interviews and lead group exercises while women core group members sit on the sidelines, how does this help improve the status of women?

- Do you have the resources to implement the tool adequately? If not, are there alternative resources that can be substituted or do you need to consider using other tools? If you are working in a community where paper is scarce, you may want to consider drawing on the ground using sticks, or working with beans or stones.
- Do the people who will conduct the information gathering process and the participants have the knowledge and skills necessary to use the tools? If some participants cannot read or write, for example, and the tool requires that they do, their participation will likely be less than others who can read and write. You can address this by changing the tool or making sure that those who cannot read or write are assisted by trusted others who can.
- Is using the tool interesting and/or fun? Do participants learn something or otherwise benefit just by participating in the information gathering process? Participants are likely to devote more time and thought to the exercises if they enjoy the process and see that it can benefit them.
- How long will it take? Using some tools requires more time than others. You will need to be sensitive to participants’ time constraints and weigh the quantity, quality, and depth of information gained against the time it takes to gather it.
- How would you feel as a participant using a particular tool? Try to put yourself in the position of others you hope will participate in this process. If some tools don’t work for you or members of the core group, consider using different ones.



Information gatherers should always remain focused on what they want to learn and change their tools if necessary rather than continue to use tools that may be fun or interesting but do not achieve the objectives of the exercise. Until you are certain that the tools you have selected work well, you may want to identify alternatives to use as necessary.

In addition to considering which tools and techniques will be most appropriate to suit the community's content and process needs, you should also consider the sequence in which they are used. Generally, as mentioned above in step 2, more intimate, complex or controversial issues should be introduced after participants have had a chance to become familiar with the person(s) gathering information, have become oriented to the theme, and feel more comfortable after having discussed easier topics. Community mapping is a good introductory tool to build rapport with community members, but the more sensitive body mapping tool should only be used once safety and trust have been established.

You should also be conscious of the new dynamic that may be created between core group and community members when the former take on their new role as "information gatherers." Information gatherers should always ensure that participants from the broader community are well-informed about the purpose of the exercise and that they be given the opportunity to decline if they choose not to participate.

### **Documenting the information**

Many of the methods mentioned above are dynamic and stimulate lively conversation and dialogue. How can information gatherers best document this information so that it is not lost to later analysis? A number of options can be considered, with some of the most frequently used methods presented in the table on the following page, in order of least invasive to more invasive. When discussing some topics and/or in some cultural contexts, individuals or groups may not want to be



Documentation Method	Skills needed	Materials needed	Level of Accuracy
Note taking after the session	Read, be able to take dictation (write quickly and legibly without interpreting or changing content), listen, speak and understand the languages spoken, good memory	Paper, pens or pencils, surface to write on	Varies markedly depending on the skill of the note-taker. As they must rely on memory, accuracy may be compromised. Usually does not record vocal inflections or nonverbal communication.
Note taking during the session	Read, be able to take dictation (write quickly and legibly without interpreting or changing content), listen, speak and understand the languages spoken	Paper, pens or pencils, surface to write on	Varies markedly depending on the skill of the note-taker. Usually does not record vocal inflections or nonverbal communication.
Audio recording (audio-cassettes/CDs)	Be able to use a tape recorder and change tapes when they run out	Tape or compact disk recorder, tapes or CDs	Good if quality of recording is adequate. When recording outside or in rooms with echoes sound can be distorted and words may be difficult to understand. Does not capture non-verbal communication.
Videotaping	Be able to use a video recorder, change tapes, follow discussion to capture speakers when they speak	Video camera, tapes	Very good if quality of recording is adequate and operator has been able to film speakers. Records exact dialogue, vocal inflection and nonverbal communication.



video- or audiotaped, though their attitude may change if they are in control of the taping. In some settings, people dislike being photographed or filmed. In one community in Bolivia, members of a women's group did not want their views on family planning written in the field notebook until they were able to ensure that the notebook would stay under their control in the community. It is always important to explain the documentation method options to participants and ask which methods are acceptable to them. They should understand what the information will be used for and who will have possession of the information when it is documented.

### STEP 4: Analyze the information.

One of the most frequently omitted steps in research and information gathering is making sense of the information that has been so painstakingly collected. In some cases, what is learned in the information gathering phase of the Community Action Cycle does not seem to be applied in the next phase (Plan Together). Sometimes this is because the planners did not participate in the community exploration, but more often it is because people don't take the time to organize the information they have gathered and decide what it means.

In this step, then, you will be trying to answer the following questions about the information you have collected:

- What are the most common underlying themes that are revealed through the results? (What phrases, reflecting attitudes, opinions, beliefs, values, and perspectives do you frequently observe in the data?)
- How are these themes or perspectives the same or different depending on the characteristics of the respondents?
- What do these results say about people's belief systems (not just individual practices but the interconnected "whys" behind them)? For example, how do women believe their reproductive processes work or how do people believe the body heals?

**Information gatherers should always remain focused on what they want to learn, and change their tools if necessary rather than continue to use tools that may be fun or interesting but do not achieve the objectives of the exercise.**

3







## INDIA: Asking the Experts

Social Action for Rural and Tribal Inhabitants of India (SARTHI) with external technical assistance used Participatory Action Research (PAR) methods to identify and understand the use of traditional remedies for women's health. Through workshops with traditional healers, forest field visits with local woman, and meetings with village elders, program participants identified flora traditionally used to treat common health problems, specifically women's reproductive health problems. The data collection and analysis methods were based on women's own reality and health belief systems, their abilities, and their common use of terms. When traditional healers were asked to name the plants they used in their practice, they would not disclose this information. Through discussions with key community informants, it was discovered that to say the name of the plant, which was considered sacred in its healing powers, was equivalent to disrespect and would result in the plant losing that power. The participants modified the method so that during field visits local women and traditional healers could point out the plants and then the name of the plant could be spoken by women who were not from the area. "In this way, the PAR became a true partnership, facilitating mutual exchange rather than just a one-way process of either extracting information for research purposes or imposing our own knowledge and beliefs in the interests of an efficient service-delivery programme, and with some of us who had received training of a different kind having to relearn."

*de Koning and Martin, 1996.*

- Are there any surprising results? Why are they surprising?
- What are the conclusions we can draw from the results?
- Which results have the most important implications for future program efforts?

There are a variety of methods that you can use to organize information that has been collected. The methods you choose will depend on the amount of information you have to analyze, the level of accuracy and complexity necessary or desired for the analysis, the level of education and skills of participants, the extent to which capacity building is an objective, and the time and resources available. Examples include tables, matrices, pie charts, bar graphs, flannelgraphs, among others.

When there is a lot of information to consolidate and present, entering the data into a computer database is helpful, and there are many software packages available. One of the most commonly used packages to store and analyze survey data is "EpiInfo" which has been developed by the U.S. Centers for Disease Control. It can be downloaded free of charge through CDC's internet site or can be ordered through the mail. For more complex analyses many academic institutions use SPSS software and other statistical software packages. If you have the technical ability to design your own database using a standard database package, this is also an option.

Information can also be consolidated manually using tally sheets (see following page) or charts if a computer is not available or appropriate. No matter which means you use to consolidate the data, it is important to ensure that the information is recorded correctly and entered correctly.





## Example of a Tally Sheet for Quantitative Data

Question	Yes	No	Don't Know	Not Applicable
Did your child have diarrhea any time during the last two weeks?	HHH HHH HHH HHH	HHH HHH HHH	HHH	

Mistakes made while entering and consolidating data will lead to inaccurate information that can later lead to faulty analysis and poor decision-making.

### Qualitative analysis

Qualitative analysis tries to identify the “whys” behind existing practices and conditions. Anthropologists are trained to be able to assist with this kind of analysis, and you may want to consider working with one to help the group. There are many ways to analyze qualitative information, as shown in the table on the following page.

If the core group and the program team do the analysis without the aid of a specialist, here are some things to keep in mind as you review qualitative information:

- Be careful to refer to the actual phrases and words that respondents used rather than try to interpret them in your own words, particularly when the same phrases appear a number of times throughout the notes, transcripts, or tapes.
- Avoid starting with a predefined framework that you then try to fill in with the results of qualitative research. This approach, while seemingly organized and systematic, may force information into a paradigm that is not consistent with how local people actually perceive the issue and





# Methods for Qualitative Data Analysis<sup>1</sup>

## Summary of Qualitative Data Analysis Media

Medium of analysis	Uses	Benefits over other media	Drawbacks	System requirements	Ability to learn on own
By hand	Low-tech analysis of interview data	Ease of use, low cost, "closeness" to data	Cumbersome with large amounts of data	Pen, paper, scissors, and large space for organizing	High potential
Search tools in word processors	Simple search and retrieve, simple coding; macros for repetitive tasks such as coding schemes	For those who already use word processors, it is a free and simple addition	Does not allow very complex searches, cumbersome	Windows 3.1-Win 95, Win98; Word 6-8 or WordPerfect 6-8 word processor	High potential
Search and retrieve software 1) dtSearch 2) ZyIndex	Complicated search and retrieve in files saved in various text formats	Can search files saved in nearly all text formats, allows complex searches	Expensive, limited use outside of searching	Windows 3.1-Win95, Win98; and word processor	High potential
Programs for semi-structured data 3) CDC EZ text	For creating, coding, managing, and analyzing semi-structured data	Data can be copied into the templates from word processing documents; data can be exported in a variety of formats	Requires a lot of time for training and for coding data	Windows 3.1-Win95, Win98, WinNT (versions 3.51 and 4.0)	Medium potential
Integrated coding and model-building 4) Ethnograph version 5.0 5) NUD*IST 6) ATLAS/ti	Search and retrieval, hypertext, theory development	Many useful qualitative analysis tools and output formats, link to quantitative software	Expensive, complicated; requires extensive training	Windows 3.1-Win95, Win98	Low potential
Software for semi-structured data 7) ANTHROPAC	Menu-driven DOS program for analyzing of sorting, ranking, and listing	Only software for this type of data, good manuals	Requires extensive training in data entry and analysis	DOS, or Windows 3.1-Win95, Win98	Low potential

<sup>1</sup> Winch, P. et al. (2000). Qualitative Research for Improved Health Programs: A Guide to Manuals for Qualitative and Participatory Research on Child Health, Nutrition, and Reproductive Health. Dept. of International Health, JHU and Support for Analysis and Research in Africa Project (SARA), Academy for Educational Development (AED).



may cause you to miss important areas of potential intervention later on. It is better to start with the raw data, look for common themes, and highlight them. Let local participants then put the pieces together to show how they relate to one another. This is particularly important for health professionals who may be seeing the universe with a more health-services focused lens than community members.

- Be aware of the diversity of individual and group respondents and take care not to lump all responses together when this may cause you to miss important distinctions between how individuals or groups think and act.
- Try to keep focused on the major issues and underlying themes rather than get lost in debating the details. When the participants have a better idea of the big issues and have set priorities, they can return to the details related to priority concerns.

### STEP 5: Set priorities for action.

For the whole community mobilization process, many choices have to be made about content, process and sequence of action, and all of these will have to be prioritized. Although some program teams prefer to include priority setting in the Plan Together phase, we have chosen to include this step in the exploration phase because our approach is to work with a core group of those most affected by and interested in the health issue. When this group is largely composed of individuals and groups that have little power in the broader community, such as poor people, women, adolescents, children or others, the risk of moving this step to the Plan Together phase is that priorities will be set by those who have more power but may not be directly affected by the issue and so do not reflect this group's concerns.

**Try to keep focused on the major issues and underlying themes rather than get lost in debating the details.**



## One Method of Setting Priorities

When the group has identified the full range of potential priorities related to the project goal, members can develop a set of picture cards representing each of these problems, conditions or issues for ranking and pile sorting. To encourage full discussion and greater participation of each group member, you may want to divide the core group into smaller groups of three to five people each. Copies of each card set can be given to these smaller subgroups to help participants organize priorities. Individuals can rank their priorities using the cards and then share their priorities with other subgroup members. Pile sorts can help the group organize the cards. Those cards that are not deemed priority by all group members can be set aside, while others can be sorted and discussed using the criteria determined above to arrive at a consensus in the group on the top priorities. When the subgroups have arrived at their priorities, they can then discuss and debate and negotiate their priorities with the other subgroups to arrive at general, core group priorities. In addition to facilitating greater participation of all group members, this process also helps members build skills, such as being able to present opinions and information in a public forum, defend their decisions and negotiate with other groups. Building and strengthening these skills is important preparation for the upcoming Plan Together phase.

## Setting priorities

If the community mobilization health issue is defined broadly, there is likely to be a large universe of potential priorities to choose from. For example, if the CM goal is to reduce child mortality in children under five years old, the community might have to choose from a number of possible problems: diarrheal diseases (dehydration), malaria, acute respiratory infections, infectious diseases (such as measles or tetanus), malnutrition, too many children in too little time, neonatal complications from delivery and postpartum period.

To decide which priorities the community will address immediately in the upcoming planning phase, participants will need to look again at the health issue in light of the information they have just gathered and analyzed and establish criteria for setting their priorities. Some suggested criteria to consider include:

- **Severity.** Is this condition/problem life-threatening? Does it lead to chronic life complications?
- **Frequency.** How many people experience the problem or condition? How often?
- **Risk.** How many people could experience it in the future?
- **Impact on the community.** What is the impact that this problem/condition has on our community now? What kind of impact could it have in the future if we don't address it?
- **Feasibility of a response.** Have any effective responses to the problem/condition been identified? Is financial, material and resource support available? Do people possess now or could they develop the necessary skills and abilities to make a difference?



- **Commitment.** Is there local political support for this problem/condition/goal? Is there external interest in addressing the issue? Are community members motivated to do something about the problem?

The team and core group should review the information gathered to rank the possible priorities until there is general agreement. It is best to try to limit the number of priorities to two or three in order to focus the group's effort.

### Strategies for dealing with conflict and disagreement

Priority setting in groups is not an easy task, particularly when participants have not done this before or when the group has only recently been formed. Group leaders may be emerging, and roles and relationships may be shifting as the group establishes its working style. Diverse groups are likely to have differences of opinion. In these circumstances, it is not unusual to see disagreement or conflict. Each culture has its own accepted practices and systems for dealing with conflict, and you should be aware of what is normally done in your setting. Additionally, there are many resources that describe various approaches to conflict prevention and resolution. Some strategies which help prevent/resolve conflict include: articulating issues on all sides, setting goals that all agree on, establishing culturally appropriate communication mechanisms for decision-making, mediating, negotiating, and determining whether there is a need to agree to disagree. Different decision-making strategies include: voting, consensus-building, letting the leaders decide, rotating priorities one time to the next, and/or adding on additional priorities. The Conflict Research Consortium at the University of Colorado has developed an excellent guide to conflict management. For further information, see resources at the end of this chapter and further discussion in Chapter 5, step 4.

# Useful Tools

## I. Work Plan for Exploration Phase Activities (Steps 2 & 3, pages 103-112)



Desired Results (content/ capacity building)	Methods	Coordinators/ Facilitators	Participants	Materials/ resources	Time needed & start-finish dates



## II. Timetable Template

### Exploration Phase Activity Timeline

When you have completed the previous worksheet, discuss how each activity relates to the others. Does one activity depend on another before it can start? Can activities happen at the same time? Plot out the timing of each on the chart below to show when these activities will be carried out. (You can also use other tools to do this or can transfer this concept to flannelgraphs or other easily manipulated graphics.) You can use this worksheet to track your progress by completing the comments/observations box with the status of activities or other notes (e.g., activity #3 postponed until \_\_ due to rain).



Activity	1	2	3	4	5	6	7	8	9	10	11	12	Comments/observations

### III. Selected Tools and Techniques for Gathering Information: Their Advantages and Limitations (Step 3, page 112)



Tool or Technique	Advantages	Limitations
<p><b>Assets-based community capacity inventory</b></p> <p>Community members inventory their community strengths and resources so that they can use and build on these strengths and resources to address the health issue.</p>	<p>This process generates energy and a “can do” attitude. Communities shift their focus from their problems to what they have and have been able to achieve.</p>	<p>A community may desire to take a problem-based approach initially in order to resolve an immediate need, such as avoiding a cholera outbreak when the disease is present in surrounding areas.</p>
<p><b>Community mapping</b></p> <p>Community members create a map of their community by drawing or using locally available objects.</p>	<p>Using the map, participants can show where individuals and families live, how many people live in each house, who is pregnant, who has a latrine and other such characteristics that relate to health and community life. Groups with different characteristics may see the community differently and facilitators often note big differences, for example, between women's maps and men's maps, children's maps and adults' maps. Maps may be used to gather baseline data on many health indicators and can be used to monitor progress over the life of the program.</p>	<p>The “community” may not be a physical place, but people who share something in common. For example, the “community” may consist of people who smoke, have diabetes, are illiterate, or play sports. In such cases a different tool would be needed to conceptualize the influential factors in these kinds of contexts.</p>
<p><b>Social networks analysis</b></p> <p>A type of mapping that shows relationships between people. Social networks analysis is often used to identify “key” influential people in the community. Interviews are conducted with a sample of community members who are asked who they talk to about certain issues. The names are collected and are then mapped out to show who talks to whom.</p>	<p>Those people who are most often consulted show up in the maps as hubs of communication. Programs might then aim to involve these people.</p>	<p>This technique may overlook principal individuals who influence community decision making in moments of crisis or severe importance, but are not integrated into everyday social networks of information exchange. In some cases, elders who hold hereditary or ritual status may be deferred to by the overall community for reasons of respect, as well as to maintain deep-rooted traditions.</p>

*(table continued on following page)*







Tool or Technique	Advantages	Limitations
<p><b>Sociograms</b> Show the relationships between local institutions, the presence of formal and informal leaders and their relations.</p>	<p>This exercise can aid community members to clarify the present structure of relationships among local institutions and leaders, as well as stimulate considerations of how to strengthen ties in efforts to achieve shared goals.</p>	<p>In some settings local institutions and leaders prioritize their own interests and members, excluding unaffiliated community members who are often those most in need.</p>
<p><b>Community history</b> Interviews or group discussions with community members who know the history of the community are recorded (on tape or written on paper).</p>	<p>Histories often illuminate how the health issue has affected the community, how the community has dealt with this and similar issues in the past, how well the community has worked together in the past (internally and with external actors) and they help to identify past and potential future areas of conflict.</p>	<p>In regions recovering from situations of violence, a community may not want to recall recent history which highlights divisions in the community, and brings back painful memories.</p>
<p><b>In-depth interviews</b> An interviewer asks another individual questions about the topic of interest.</p>	<p>Helps to gain an understanding of the interviewee's experience, knowledge, beliefs, and attitudes.</p>	<p>Interviewers must be well-trained; depending on the topic, it may be necessary that the interviewer and person interviewed share basic characteristics (language, gender, age, socioeconomic class).</p>
<p><b>Brainstorming</b> Using "metacards" to draw or write thoughts</p>	<p>Equal opportunity for expression is achieved as every participant is invited to share a perspective or opinion; the cards can be easily sorted and grouped into categories.</p>	<p>Facilitators must be trained and confident of their ability to guide and order the ideas and discussion. A given group may not be accustomed to working with materials such as pens and paper.</p>
<p><b>Socio-dramas and role plays</b> An individual or group of participants develops and then presents a skit (drama) related to the health theme while other participants observe.</p>	<p>Productive discussions can emerge on what they observed, in order to reflect and interpret meanings and make decisions.</p>	<p>Some groups may be unfamiliar, and therefore unwilling, to play act hypothetical scenes or reenactments.</p>
<p><b>Videotaping</b> Documentation of group discussions for analysis and discussion.</p>	<p>Serves as a valid testimony of attitudes, perceptions, and recounting of experiences. Can be a reflexive tool for people to see and hear how they present themselves in public forums in order to improve clarity of expression.</p>	<p>A community or project may lack equipment and access to electricity for this technique.</p>
<p><b>Values clarification and attitude scales</b> Activities and games focused on values and attitudes.</p>	<p>Aid to underline the range of attitudes among a group of individuals, and to identify shared and differing values.</p>	<p>The expressions of some groups may be swayed by strong opinion leaders whom the participants tend to publicly "side" with.</p>
<p><b>Venn diagrams</b> Abstract shapes such as circles drawn to depict relationships.</p>	<p>Can help to visualize perceptions of the relationship between or among local institutions.</p>	<p>This exercise may remain abstract, and not correspond to a given group's way of depicting relative associations.</p>

# Resources

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- Annett, H. and S.B. Rifkin. (1995). *Guidelines for Rapid Participatory Appraisals to Assess Community Health Needs*. Geneva: WHO/SHS/DHS/95.8.
- Catholic Relief Services. (1999). *Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA): A Manual for CRS Field Workers and Partners, Vols. I & II*. Baltimore: Catholic Relief Services.
- Centers for Disease Control. (1996). "The Use of Theory Based Semi-structured Elicitation Questionnaires: Formative Research for CDC's Prevention Marketing Initiative." *Public Health Report*, Vol. 3, Supplement I.
- Chambers, R. (1992, October). *Rural Appraisal: Rapid, Relaxed and Participatory*. Sussex, UK: Institute of Development Studies, Discussion Paper 311.
- Conflict Research Consortium. Boulder, CO: University of Colorado website at <http://www.colorado.edu/conflict/peace>
- Covey, S. (1990). *The 7 Habits of Highly Effective People*. New York: Simon & Schuster.
- de Koning, K. and M. Martin. (1996). *Participatory Research in Health: Issues and Experiences*. London: Zed Books.
- de Negri, B., E. Thomas, A. Ilinigumugabo, I. Muvandi, and G. Lewis. (1998). *Empowering Communities: Participatory Techniques for Community-Based Programme Development, Vol. 1(2): Trainer's Manual (Participant's Handbook)*. Nairobi: The Centre for African Family Studies (CAFS), in collaboration with the Johns Hopkins University Center for Communication Programs and the Academy for Educational Development.
- Huizer, G. (1997). "Participatory Action Research and People's Participation: Introduction and Case Studies." *SD Dimensions*. Rome: Sustainable Development Department, FAO.



- Institute of Development Studies. (1996). "PRA Methods and Topic Packs." Sussex, UK: Institute of Development Studies.
- International Institute for Environment and Development. (1995). *A Trainer's Guide for Participatory Learning and Action*, London: International Institute for Environment and Development.
- . (1995). *Participatory Learning in Action Notes*. London: Sustainable Agriculture Programme, International Institute for Environment and Development.
- Kruger, R. (1994). *Focus Group: A Practical Guide for Applied Research*. Thousand Oaks, CA: Sage Publications.
- Margoulis, R. and N. Salafsky. (1998). *Measures of Success: Designing, Managing and Monitoring Conservation and Development Projects*. Cavelo, CA: Island Press, p. 134.
- Schubert, B. et al. (1994). *Facilitating the Introduction of a Participatory and Integrated Development Approach (PIDA) in Kilifi District, Kenya*. Vol. II (Methods). Berlin: CATAD.
- Scrimshaw, SCM and E. Hurtado. (1987). *RAP for Nutrition and Primary Health Care: Anthropological Approaches to Improving Program Effectiveness*. Los Angeles: UCLA Latin American Center.
- Selener, D. (1998). *Participatory Action Research and Social Change*. Ithaca, NY: Cornell Participatory Action Research Network.
- Shaver, T. (1993). *Drawing as Dialogue—A Qualitative Approach to Needs Assessment for Health Education Planning*. Liverpool, UK: Liverpool School of Tropical Medicine, Education Resource Group.
- The World Bank. (1993). *Participatory Evaluation: Tools for Managing Change in Water and Sanitation*. Washington, DC: The World Bank.
- . (1994). *Participatory Development Tool Kit: Materials to Facilitate Community Empowerment*. Washington, DC: The World Bank.
- . (1996). *Towards Participatory Research*. Washington, DC: The World Bank.
- . (1998). *Participation and Social Assessment: Tools and Techniques*. Washington, DC: The World Bank.

- Theis, J. and H. M. Grady. (1991). *Participatory Rapid Appraisal For Community Development—A Training Manual Based on Experiences in the Middle East and North Africa*. London: International Institute of Environmental Development.
- USAID. (1999). "HIV-AIDS Care and Support Initiatives via Community Mobilization." Synthesis Paper for USAID/Displaced Children and Orphans Fund.
- Welbourn, A. (1994). *Participatory Rural Appraisal and needs analysis: Whose Knowledge counts?* Kenya: Proceedings of the International Symposium on Participatory Research in Health Promotion.

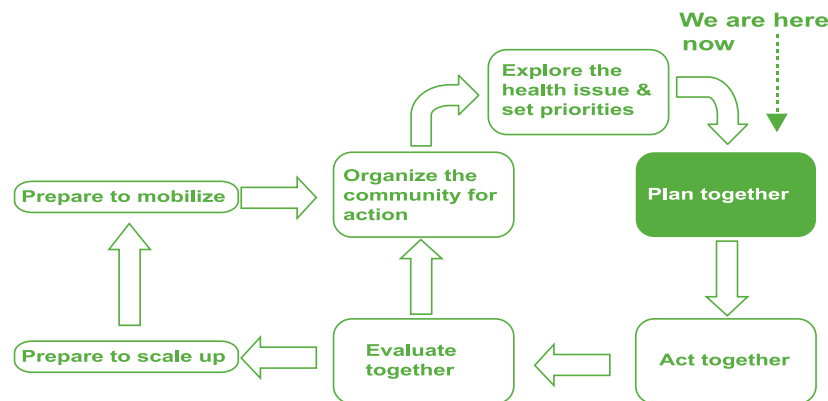


# Chapter 4

## Plan Together

1. Decide the objectives of the planning process
2. Determine who will be involved in planning and their roles and responsibilities
3. Design the planning session
4. Conduct/facilitate the planning session to create a community action plan

4



“Our most urgent need is not for a master plan for all communities but for plans that are based on the views and needs of the people, developed with the people, and subject to modification by the people.”

Patrick G. Boyle, "Adult Education and Community Analysis: Redefining the Discipline of Adult Education"

### Why plan together?

Many questions arise when we consider bringing different individuals and groups together to plan. Why do we need to plan together at all? Won't people just take action once they are aware of the health issues? Why not develop an action plan only with the core group? They are the ones who are most affected by the problem.



Why not develop an action plan only with community leaders and health workers? They have the knowledge and power to do something about the problem. Why doesn't the program team develop the plan and then present it to the leaders for approval? The team has already talked to everybody and is paid to do this. Why go to all the trouble of bringing together all these people who sometimes don't even speak the same language?

These are among the questions we will consider in this chapter. As in all previous chapters, we are assuming for the purposes of this field guide that the program team members are not from the community (as the core group is) but belong to an external organization.

It is important to keep the underlying themes (see Chapter 1, page 20) and group development stages, including "forming," "storming," and "norming" in mind as you develop the planning process (see Chapter 2, page 78).

## STEP 1: Decide the objectives of the planning process.

Before beginning to plan, it can be helpful to determine the purposes of the planning process. Many teams do this informally, but it helps to be more systematic and explicit.

One way or another, planning ultimately comes down to answering six key questions. The community action plan you end up with at the conclusion of your planning together stage should clearly describe the following:

1. **What** you would like to achieve.
2. **How** you will achieve it.
3. **Who** will be responsible for each activity and for results.
4. What **resources** you will need and how you will obtain them.
5. **When** and **where** you will implement your activities.
6. How you will **monitor** your progress and know when you have achieved your results.

The planning process itself will also have objectives (beyond producing the plan, that is). Here are some examples of planning process objectives that program teams and communities might also want to achieve during this phase:

- Ensure that key policy and decision-makers, community leaders, and health service providers support and contribute to the program.
- Ensure that those who are most affected by the CM health issue set the agenda and have a meaningful voice in the planning process.
- Enlist technical assistance from external organizations that have desired expertise.
- Identify and leverage needed resources to carry out the strategies that are developed.
- Ensure that what was learned through the exploration and investigation of the CM health issue is applied to the planning process.
- Strengthen community, individuals' and organizations' analysis, planning, and negotiation skills.

- Build community confidence to take collective action.
- Build community leaders' skills to facilitate a planning process that integrates those who are most affected by the CM health issue.
- Establish new communication channels and relationships between community actors.
- Ensure that opposing points of view can be voiced and discussed in a constructive manner.

It is important to work with your team and core group members to determine planning process objectives. Additionally, at the beginning of the joint planning process with the broader community, you should ask participants how they would like the planning process to proceed, so that their expectations are clear. If some expectations cannot be met, it is important to discuss why.

## STEP 2: Determine who will be involved in planning and their roles and responsibilities.

Who will participate and how they will participate are critical questions. Equally important is who asks and answers these questions. Often, when groups answer the question—“Who should be involved in planning?”— the list grows until the response ends up being everyone. While involving everyone in the planning process may be desirable from a participation perspective, the core group and others involved in determining who should be invited need to consider the advantages and disadvantages of managing a large group versus a smaller, more defined group. In some situations, not inviting everyone in the community might offend those who were not invited, while in other settings it is not expected that everyone would be invited and no offense is taken. This is clearly a potentially sensitive subject that can affect future implementation of the program. It is as important to ask who is not invited and why as it is to ask who is invited.







Here are some questions to help the core group and others decide who should be invited to participate in the planning.

- Is the person/group directly affected by the CM health issue?
- Is the person a local leader (formal or informal) or key opinion leader?
- Is the person very interested in the CM health issue?
- Does the person/group make or influence decisions or have access to information or services for those who are directly affected by the CM health issue?
- Does the person/group possess special skills, knowledge, or abilities that could help the planning group make more informed decisions or implement the action plan when it is completed?
- If the person/group was not invited, would s/he/they try to obstruct implementation of the action plan or create other problems?
- Would potential strategies to address the CM health issue require this person or group's assistance or approval?

If the answer to any of the above questions is “yes,” the person or group should be considered for the invitation list. You may want to add criteria to this list of questions. You may decide that it is worthwhile to invite the whole community. There are no hard rules to follow, but you should make a conscious effort to consider who is participating and why, so that you can better structure the process and help participants understand their respective roles and responsibilities.

## PHILIPPINES: The Usual Suspects

In 1998-1999, a program team initiated work with Filipino community leaders in rural and urban communities using an appreciative approach (Appreciative Community Mobilization [ACM]) to mobilize around family health, including child survival and family planning.

The ACM program team noticed that community planning and decision-making was limited to a small circle of community leaders who did not involve other community members in the process. As a result, community projects were benefiting families that were more politically connected and generally better off. Adapting an appreciative inquiry methodology developed by the GEM Initiative of Case Western Reserve University, the team worked with community leaders to apply the “4-D” cycle (Discovery, Dream, Design and Deliver).

The community leaders went through the initial discovery and dream phases as a group. Then the program team asked the leaders whether they thought that others in the community had the same dreams as they had, whether it was important to know this, and how they could find out. The leaders believed that it was important to know because they realized that many of the families that were experiencing family health problems were also the families that normally did not participate in community activities such as general community meetings. The leaders decided that they should repeat the discovery and dream phases in the *sitios* (neighborhoods) of the community to learn what these families' priorities were. Through this process, the leaders also identified priority families (“the families that we should take care of first”). When they had completed the process in every *sitio*, the leaders met again to consolidate results and consider how to set priorities for the entire community. They then went to the *sitio* level again to work on the “design” and “deliver” phases.

In addition to broadening participation in setting priorities, the community leaders learned how to facilitate a more participatory planning process, how to listen and respond to community families (especially “priority” families), and how to plan more systematically while building on community strengths and resources.

*Save the Children Federation (US), Philippines field office*

## Roles and responsibilities

As when preparing for any group session, many tasks must be done to ensure that everything runs smoothly. Distributing these tasks among team and core group members helps to strengthen teamwork, build organizational skills, and foster accountability. When distributing responsibilities, ask first for volunteers. Some key functions that need to be carried out include session design, facilitation, logistics, and documentation. If some group members are interested in doing a particular task but are unsure as to whether they can—particularly if they have never done the task before—they may want to consider pairing up with someone who has some experience to boost their confidence.

In general, the program team should try to encourage the core group to take on as much responsibility for the planning session as the members can. Program team members are then free to work more as consultants or advisors than as organizers and facilitators. However, there may be times when it is better to have a more neutral, external facilitator conduct the planning process, such as when other participants initially perceive core group members negatively or when it is important for core group members to actively participate as equals with other participants. Core group members and the program team should openly discuss who should facilitate the session(s) to determine the pros and cons of various options.

The facilitator is clearly a key role. Here are some general criteria to consider as you determine who best to facilitate the planning process:

- Facilitation skills
- Interpersonal skills
- Technical expertise in health, group dynamics, planning
- Language and communication skills
- Cultural sensitivity and awareness
- Gender equity
- Representation and inclusion



### Step 3: Design the planning session.

In step 1 you determined what you hope to achieve through the planning process which, ultimately, should be an agreed-upon blueprint for community action to address the CM health issue. And in step 2 you determined who should be invited to participate in the planning process.

Now it is time to prepare for the actual planning session when you will bring together the participants you have selected to design the community action plan. You may want to review general facilitation guidelines and experiential learning principles as part of your preparation, and the core group should review its findings and priorities from Chapter 3 to identify important information that needs to be incorporated into the planning session.

In designing any participatory group process, you need to first think about planning from the participants' point of view. What are their needs and expectations? What have we learned about what participants now know and do in relation to the CM health issue? What planning and other relevant skills do they possess? What are the existing power relations between participants? How do participants relate to each other? What has been their prior experience participating in groups and with planning processes in particular? How does the cultural context in which they live affect how they are expected (or expected not to) participate in collective action (age, sex, ethnic group, socioeconomic class, political or religious affiliations)? Is there a wide range of experience or is the group fairly homogeneous? Will there be more men or women? Will participants be representing other organizations or individuals or are they participating as individuals?

You may also find it helpful at this point to observe how community members plan other activities and incorporate important lessons or activities. Generally, participatory planning should build on existing skills and knowledge and help all participants to:

**In designing any participatory group process, you need to first think about planning from the participants' point of view. What are their needs and expectations?**



- Know what is happening and why (purpose of the meeting, what the group tasks are).
- Feel safe and comfortable to express themselves.
- Challenge assumptions and think creatively.
- Contribute their knowledge, experience and skills in positive ways that are helpful to the group.
- Share and maximize the collective experience of the group.
- Produce an action plan that clearly states what they want to achieve and how they intend to do it.

### Creating a community action plan: 16 key tasks

This section describes 16 of the most common tasks involved in creating a community action plan. When you hold your planning session with the community, some or all of these tasks will form the essence of that session and be the means whereby participants will design their community mobilization effort.

Before you hold that session, however, you need to become familiar with these 16 tasks and carefully plan how you are going to execute them when the time comes. Your planning session(s) may not follow this sequence exactly, and you may add or omit certain items, but this list gives you a general idea of the most important tasks to be accomplished.

Your job during this step of the Plan Together phase is to do the following:

1. Review the 16 tasks described below and decide which ones are appropriate for your situation and then delete or add tasks as necessary.
2. Decide on the sequence of the tasks.
3. Decide who will be responsible for facilitating each task.
4. Decide how these tasks will be carried out.
5. Decide what materials or tools will be needed to carry them out.
6. Decide on any other matters that need to be arranged before the planning meeting.



In the list that follows, the descriptions explain what should happen vis-à-vis each task at the actual planning session, and the word “participants” refers to the attendees at that session. As you read this list, your focus should be on what you have to do now—in *preparing* for the session—so that the activity described under each task can be successfully carried out.

**Task 1: Orient participants to the overall goals of the CM program.** Even though many of the participants may already have heard about the program, it is important to review the goals of the program, the timeframe, and who is involved in the program.

**Task 2: Clarify the specific objectives of the planning process.** Participants should understand what they are trying to achieve in this planning session. As mentioned earlier, the program team/meeting facilitators may want to do an exercise to clarify participant expectations and address any of their concerns now.

**Task 3: Consolidate and review relevant information.** This is the time for core group members to present what they have learned during the Explore the Health Issue and Set Priorities phase. Participants need to be able to have a chance to ask questions, discuss the relevance of the information to the community and contribute their knowledge and experience of the health issue (and you should, accordingly, plan for such a discussion).

*(Note: During the actual planning session, you may want to organize the information generated by the following tasks, 4 through 10, using the Community Action Plan Matrix presented at the end of the chapter as Useful Tool II.)*

**Task 4: Develop a consensus on program priorities, objectives, desired results or other indicators of success.** During the planning session, the participants will need to agree on priorities. These priorities should be stated in a positive way so that they can be seen as “desired results,” “dreams,” or “objectives.” For example: “All people of reproductive age in this community will have access to family planning information and services.” Or: “We will have no reported cases of measles in this





## MALAWI: Whose Priorities?

In a concerted effort to develop greater youth ownership and control over a Malawi-based adolescent reproductive health program, youth were trained in focus group methods, developed their own questionnaires, and were supported during their fieldwork as they collected information from other youth, parents, and healthcare providers in their community. They consolidated and analyzed the results from their focus groups, together with program staff, in preparation for the joint strategic planning meeting that would determine the program's priorities, approach, strategy, and activities.

An unprecedented mix of concerned youth, healthcare providers, religious leaders, teachers, government officials, and local and international NGOs attended the planning meeting. Youth helped prepare and facilitate the meeting, participating even as daily chairpersons. Planning participants reviewed the data collected from the youth focus group discussions and secondary data from government statistics and health facilities. Young girls presented startling findings of beatings that resulted from having refused sex, encouragement from family members to engage in sex for money or goods due to conditions of poverty, and pressure from local 'sugar daddies' to exchange sex for shoes or food. During the planning workshop, however, the young girls repeatedly tried to bring up these important findings but were continuously dismissed for having exaggerated the situation or they were "out-voiced" and accused of being 'silly' by either young boys and/or the adults—many times by the older men in the group.

Ultimately, the whole issue of "sugar daddies" was left out of the plan because they (the sugar daddies) were actually the ones making the decisions about priorities in the meeting. This missed opportunity might not have happened if a core group including the young girls affected by the problem had decided on the priorities *before* going into the planning session. They then could have said in the meeting "These are our priorities and let's deal with them."

*Save the Children Federation (US), Malawi field office*

community by the end of this year." Prior to the meeting, you may want to ask health service providers what kinds of relevant indicators the national health system recommends to measure progress in health status related to the community mobilization health issue.

As readers will have seen in the previous chapter, this field guide actually recommends that the core group set priorities at the end of the exploration phase. The reason for suggesting this approach, i.e., that the core group set priorities before this general planning session, is to better ensure that individuals with less power (who are usually the ones most affected by health issues and who should, therefore, be part of the core group)—to ensure that such individuals are at least listened to, which is often not the case in a more open forum such as this planning session. (In the example from Malawi, we see how even when those with minimal power help design and facilitate the planning process, their voices can *still* go unheard.) If this particular problem is not an issue in your community, you may want to move priority setting into the planning session.

**Task 5: Identify resources, opportunities, challenges and constraints.** When the participants have agreed upon their desired results, they should then reflect on their current situation and what it will take for them to get to where they want to go. As they do so, they will begin to identify challenges they will need to plan for, opportunities that may open up new possibilities, resources they may need to reach the objective, and barriers or constraints they may have to overcome. It helps for participants to be specific here and provide concrete examples rather than talk in general, abstract terms. Some techniques you may want to consider using to make this exercise more real include: role playing, socio-dramas or skits, story telling (real stories or composites of real stories), making an inventory of participant knowledge and skills, and identifying potentially available public and private resources.





**Task 6: Develop a variety of strategies to achieve the desired results.** Developing strategies can be a fun and creative process for participants. Encourage participants to think of as many strategies as possible to achieve a desired result before they select one or two. The brainstorming process should allow for “crazy” ideas that may spark new thinking that may ultimately lead to effective new strategies. At the session, the facilitator can help the creative juices flow by giving some funny examples or, better yet, ask participants to vote for the funniest/most outlandish idea presented.

To help participants develop strategies, the facilitator may suggest the following:

- Think of strategies that you have used in the past that have been successful. What made these strategies successful? How can you apply what you have learned to this exercise?
- Imagine that you could enlist anyone to help you. Who would you enlist? Why? What would that person do to achieve the desired result?
- Think of what your community does better than any other community you know of. What skills, systems and resources contribute to your community doing this so well? How can these be utilized to help you achieve your objective?
- Organize participants in smaller groups that may be based on gender, age, occupation or another common characteristic that may influence their perspectives. Then ask the groups to develop strategies for the same desired result. When the groups are ready, they can present their ideas to the other groups.
- Ask individual participants to think of their own strategies before they work with a group. This process may encourage more independent, creative thinking that can then be contributed to the larger group.



**Think of strategies that you have used in the past that have been successful. What made these strategies successful? How can you apply what you have learned to this exercise?**

**If participants are aware of the root causes of health or other problems, they will develop more effective strategies.**

During this strategy forming stage of planning, many groups include an exercise on determining root causes, such as the “problem tree” activity. The assumption is that if participants are aware of the root causes of health or other problems they will develop more effective strategies. This exercise can be very enlightening to illustrate how the larger environment and other factors affect individuals’ health status. Through the exercise, participants come to realize that poverty, social injustice, and other macro-forces are ultimately responsible for many people’s poor health and other social problems (although one could argue that many community members are already aware of this). (A more detailed description of the problem tree exercise can be found in the *Nonformal Education Manual* listed in the resources at the end of this chapter.)

The problem tree is visually appealing to many facilitators and the discussion that it generates is rich, making it popular to use. However, it can sometimes overwhelm participants involved in a planning process if they believe that they must work on these difficult macro-issues before they can hope to address their health concerns. Additionally, some cultures view causality very differently from a more linear western concept. While communities no doubt need to grapple with these issues—and they do every day—your team should carefully consider whether this exercise will help participants plan more effectively.

**Task 7: Select strategies with the most potential to improve health.** Once participants have developed a number of strategies to choose from, they will need to select one or two to develop further. Establishing selection criteria, such as those listed below, will help participants better assess a strategy’s potential.

- Feasibility. Can we do it? Do we have the necessary resources, skills, time?
- Reasonable costs
- Probability of success in improving health
- Political support
- Available resources
- Easy to understand, clear
- Length of time needed





During this selection process, it is important to pay attention to whether there are any hidden agendas or unrealistic expectations. The facilitator needs to remind participants to be realistic while also allowing them to envision a better reality.

**Task 8: Specify activities, resources needed and how resources can be obtained.** If participants have carefully thought through the earlier tasks, it will be relatively easy for them to specify activities. If the participants have very limited experience with group planning, the facilitator may want to take them through the exercise in the chart on this page.

**Task 9: Assign responsibilities.** Participants need to determine who will be responsible for each activity and the desired results. Rather than delegating everything to the formal community leader, which often happens, community members might want to consider who would be most effective implementing each activity and how best to share responsibility so that activities can be accomplished more efficiently while building a broader community skill base. Does the person have the time necessary to accomplish the task? Would it be better for one person or a group to do it?

Simply *assigning* responsibilities will not be enough if the assignees don't have the knowledge or skills they need to complete the tasks. Part of your plan, therefore, may have to include knowledge and skill building elements. In the Act Together phase (Chapter 5), we will go into more detail on how to strengthen the group's capacity to carry out its activities.

Learning to Plan in Groups: Building on what we already know		
This exercise demonstrates how participants in a community health planning process can apply what is familiar to them (see second column below using agricultural planning as an example) to planning something they may not be familiar with (a health intervention). It shows how their knowledge can be generalized and applied in other contexts.		
Planning Questions	Planting example	Vaccination example
What do you want to achieve? (Goal)	<i>Food to feed my family and income to pay for school fees and other household expenses.</i>	<i>All the children in our community will not be sick with diseases that can be prevented by vaccination.</i>
What will you see when you achieve your goal? (Desired results; objectives.)	<i>X# bushels of wheat, X# bushels of peas, etc.</i>	<i>All children one year and older will be completely immunized.</i>
What things do you need to keep in mind as you decide how you want to do it? (opportunities, challenge constraints, resources)	<i>How much land I have, predictions for rain this year, amount of money I have for seed, amount of time it will take, # helpers who know how to plant.</i>	<i>How much vaccine we have, # people who can help, time, whether parents will come, cold chain.</i>
How will you do it? (strategy) (Ideally, you would generate alternatives here first and then select the most promising one.)	<i>We will plant X# hectares with wheat, X# with peas and will leave X# fallow.</i>	<i>Work with community groups to increase awareness. Vaccinate at the market every week and at health post every day.</i>
Describe step by step how it will be done. (activities)	<ol style="list-style-type: none"><li><i>Schedule people to help</i></li><li><i>Purchase seed</i></li><li><i>Prepare the soil.</i></li></ol>	<ol style="list-style-type: none"><li><i>Ensure that cold chain is in place.</i></li><li><i>Meet with community leaders and organizations.</i></li><li><i>Train vaccinators.</i></li></ol>
What will you need to do it? (resources)	<i>Money, seed, 3 helpers X# hectares of land.</i>	<i>Vaccine, 4 vaccinators 4 thermoses.</i>
When will you begin? How much time will it take?	<i>May 15, 2000 5 months</i>	<i>June 1, 2000 to December 31, 2000</i>
How will you know when you have succeeded? (indicators)	<i>We will have produced X# bushels of ____.</i> <i>My family will have 3 meals/day for 6 months.</i> <i>I will be able to pay school fees &amp; will have \$_____ left for household expenses.</i>	<i>By December 31, 2000, at least 80% of children one year and older will be completely immunized.</i>

**Task 10: Determine timelines.** When community groups are excited about beginning to work on an issue, they often propose that everything be initiated immediately or very soon after the planning meeting. The facilitator's role is to help them think through whether their proposed timelines are realistic. Participants should consider whether the dates they propose would conflict or opportu- nely coincide with other community activities. What happens if implementers encounter a delay? How will this delay affect the other planned activities? More literate groups may use tools such as Gantt charts (see example below) to help them visualize when activities will occur. If you think it will help a less literate group, you can adapt the Gantt chart concept using a more pictorial tool. For example, you could ask participants to draw pictures of special events that occur each month of the year that will serve as headings and then place pictures of planned activities in the corresponding month row or column. Whatever tool is used, it needs to be included in the final, formal plan so that it can be used as a planning and monitoring guide.



Desired Results/ Activities	1 Jan	2 Feb	3 Mar	4 Apr	5 May	6 Jun	7 Jul	8 Aug	9 Sep	10 Oct	11 Nov	12 Dec
<b>80% of children &gt; 1 year will be completely immunized</b>												
1. Establish cold chain	X	X	X	X								
2. Train vaccinators					X	X						
3. Meet with community members to plan market day vaccination activities						X						
4. Weekly market day vaccination sessions						X	X	X	X	X	X	X

**Task 11: Establish or reaffirm coordination mechanisms.** Some planning sessions result in wonderful plans, but the plans are ultimately never followed because the group failed to establish coordination mechanisms during the planning session. It is especially important to discuss how coordination will be done when

there are a number of organizations or individuals who have not worked together before in any formal way. Here are some questions you can include in the planning session to begin this discussion.

- How are we going to make sure that these plans are carried out?
- Who will track our progress?
- How often will we need to review our progress?
- What happens if we need to change our plans?

If participants decide they would like to form a coordination committee, they will need to determine what committee members will do, what criteria will be used for selection, and how selection will occur. It is usually better to determine this during the planning session when all participants are present, unless there are very good reasons to postpone it.

**Task 12: Determine how the community will monitor progress.** The group should also consider how it would like to monitor progress. Two of the most common types of monitoring, process and outcome, are briefly illustrated below.

Process monitoring asks:

- Are we doing what we said we would do?
- How well are we doing it?
- What difficulties or challenges have we faced?
- What have we learned?



Outcome monitoring asks:

- Are we achieving our desired results?
- health status?
- health indicators?

**Planning together is hard work and participants should be congratulated when they have completed a draft or final plan. This is very important.**



- our capacity to address our health needs?
- changes in health policies including resource allocation for health programs?
- What other spin-off effects and outcomes do we see from our efforts?

You should consider the level of experience of the group and time considerations to help you structure this part of the planning process. For less experienced groups, it may be enough to introduce the concept of monitoring and then plan another session later on that goes into more depth on monitoring tools and techniques.



If you use a type of planning matrix such as the one in Useful Tool II, it can easily be converted into a monitoring tool by adding three more columns to the right side of the matrix, one entitled “status,” one entitled “observations/comments,” and one called “next steps” to monitor progress on process and outcome indicators. (See Useful Tool III)

**Task 13: Determine next steps and congratulate the group.** The planning participants should be given the opportunity to determine immediate next steps. If they need to present their draft plan to others before they can commit to it, they should determine when they will do this and who will do it. They should establish a time and place for their next meeting and identify who needs to attend. They may have other next steps that they would like to work out before leaving the group. It helps to write these agreements down.

Planning together is hard work and participants should be congratulated when they have completed a draft or final plan. This is very important.

**Task 14: Present draft plans to the broader community if appropriate.** As mentioned above, sometimes participants would like to seek broader community support for the plan before they commit to it, particularly if they represent others in the community who were not present during the planning sessions. A community meeting or assembly is an easy way to accomplish this.



**Task 15: Revise plans (if necessary) based on feedback.** When participants share the plan with others, they may get helpful feedback that will need to be discussed with the other members of the planning group. The plan may need to be revised before it is finalized.

**Task 16: Finalize plans in a formal document.** The final action plan should be a formal agreement. Communities often have traditional practices to recognize formal agreements, and these practices should be honored. For example, some communities ask all participants to sign and seal or stamp the agreement. They may celebrate the agreement with a meal or dance. Ask participants how they would like to celebrate.

Once a plan is in “final” form, communities can still modify it. Indeed, it should be a living document. However, recognizing that the plan has been agreed to publicly means that implementers are accountable to others in the community when they change directions.

These, then, are the key tasks and activities involved in creating a community action plan. Now that your planning team has reviewed these tasks, you are in a position to prepare for the planning session by answering the six questions posed at the bottom of page 138.

One final task you have is to create an agenda for the planning session. The sample shown here is from an HIV program in Malawi:

#### **Planning Together Agenda for an HIV/AIDS Program**

1. Welcome
2. Introductions (with icebreaker/warm up)
3. The AIDS Community Mobilization Program: Goals and objectives
4. Goals and objectives of this planning session
5. AIDS in our community: Results from our community assessment and analysis
6. Planning to take action on AIDS
7. Planning how we will work together and monitor our progress
8. Next steps

## STEP 4: Conduct/facilitate the planning session to create a community action plan.

Now that you have completed your preparations for the planning session, it is time to conduct the meeting. As with any group session, it is important to arrive early, set up the rooms or space appropriately, and initiate the process.

Many things can and often do go wrong, so you should remain alert and flexible. A good sense of humor helps. Let's look at some common challenges that facilitators face during the planning session.

- *There isn't enough time to complete all planned tasks.* The facilitator needs to prioritize which tasks are most important and/or cut some time from some tasks. Think about the purpose and objectives of the planning process and let them guide decision-making.
- *Participants are completing all the tasks but are coming up with strategies that are not likely to have any impact on health status.* To what extent should the facilitator step in here? Is it better to let participants learn from their experience that the strategy is not likely to have an impact? Is it possible that the strategies may have a positive impact on health but you don't see it because of your own assumptions? Do participants have limited or different knowledge of how to address the health problem? Is it the process design that is at fault? Are there other agendas that are making their way into the planning process? Your team will need to carefully analyze what is happening here. Ask participants how they think the strategy will affect health to better understand the thinking behind the strategy.



- *The participants have developed strategies that will impact favorably upon health outcomes but are not within the health sector (e.g., road improvements to facilitate emergency transport), and your organization only has resources and technical expertise to assist with health projects.* As a facilitator in this process, your organization does not need to, nor should it, financially or materially support every community strategy. You can help participants think about how they can link with other organizations and resources internal or external to their community. Acquiring the knowledge and skills to access and manage valuable resources and relationships is a major achievement of many community groups that go on to apply these skills to further improvements in other aspects of community life.
- *The participants are stuck.* Should facilitators share experience from other places? This will depend on your approach and philosophy. Generally, it is acceptable and may be desirable for the facilitator to share information if she or he believes that it will help the group. For example, she or he may share another community's approach to help the group get out of a rut or to spark the creativity needed to think of new strategies. The intent should *not* be to manipulate the group into deciding on a predetermined strategy.
- *Participants cannot agree on a strategy.* If after presenting all the reasons for each competing strategy, participants can still not agree, there are several things the facilitator can do. Participants can agree to disagree and decide to try both strategies (if this is feasible) to see which one works best. They can try to combine the strategies if possible. They can seek a new strategy that all agree to by determining what they are trying to accomplish and exploring new approaches to it. They can decide to collect more information on each proposed strategy before making a decision. Or they might decide to postpone any decisions until a future date when they may have thought of other options. What other ways can you think of to deal with this situation?

**Generally, it is acceptable and may be desirable for the facilitator to share information if she or he believes that it will help the group.**

Discuss with your team and core group ahead of time what you will do if these problems arise during the planning session. And try to think of others. If you experience difficulties conducting the session, it may help to review your assumptions about the participants, the planning session and how the community views health. Problems usually stem from how we have conceived of and developed the planning session. Facilitators can use breaks and meal times to meet and discuss necessary adjustments.





# Useful Tools

Task	Person(s) responsible	Check when completed
<b>PRIOR TO PLANNING SESSION:</b>		
Determine purpose(s) of planning session		
Determine who should be invited to participate & how they will be invited		
Design planning session		
Determine when planning session(s) will be		
Determine where planning session(s) will be		
Schedule space		
Invite participants and follow up to see if they are coming		
Prepare facilitators/presenters (prepare results from situational analysis of health topic; and don't forget underlying themes)		
Arrange food (if applicable)		
Prepare materials for planning session(s)		
<b>DAY OF PLANNING SESSION:</b>		
Set up the room(s) (chairs, tables, materials, etc.)		
Make sure all facilitators/presenters know when they will be facilitating/presenting		
Greet participants		
Conduct the planning session according to the session design (modify as necessary)		
Establish monitoring and coordination mechanisms with participants		
Determine next steps with participants		
Conduct evaluation of the session with participants		
After the session, with facilitators/presenters/core group, review how the session went		
Revise the planning session design based on group feedback		



## I. Planning Checklist (Steps 1-4)

This table is an example of a checklist that your team and the core group can adapt to track your progress as you prepare for the planning session.

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## II. Community Action Plan Matrix (Step 3, page 139)



### PLAN TOGETHER MATRIX Example from Building Bridges for Quality Project- JHU PCS4 -Peru

<b>DESIRED RESULTS/ OBJECTIVES</b>  What do we want to achieve specifically related to _____? (e.g., health service facilities)	<b>BARRIERS/ CONSTRAINTS</b>  What challenges do we think we will face in trying to achieve this result?	<b>TASKS/ ACTIVITIES</b>  What are we going to do to achieve the result? (activities)	<b>PEOPLE RESPONSIBLE</b>  Who is responsible for each activity (and for the end result)?	<b>RESOURCES</b>  What resources do we need to achieve the result?	<b>TIMELINE</b>  When? How much time is needed for each activity? (from _____ to _____)	<b>INDICATORS OF SUCCESS</b>  How will we know when we have achieved the result? (measurable, observable outcomes)



### III. Monitoring Matrix (Step 3, page 146)

#### Sample Monitoring Tool Based on Action Plan

DESIRED RESULTS/ OBJECTIVES	BARRIERS/ CONSTRAINTS	TASKS/ ACTIVITIES	PEOPLE RESPONSIBLE	RESOURCES	TIMELINE	INDICATORS OF SUCCESS	STATUS	OBSERVATIONS & COMMENTS	NEXT STEPS
What do we want to achieve specifically related to _____? (e.g., health service facilities)	What challenges do we think we will face in trying to achieve this result?	What are we going to do to achieve the result? (activities)	Who is responsible for each activity and for the end result ?	What resources do we need to achieve the result?	When? How long is needed for each activity? (from ___ to ___)	How will we know when we have achieved the result? (measurable, observable outcomes)	(Desired results and completion of activities)  _____ (date)		



# Resources

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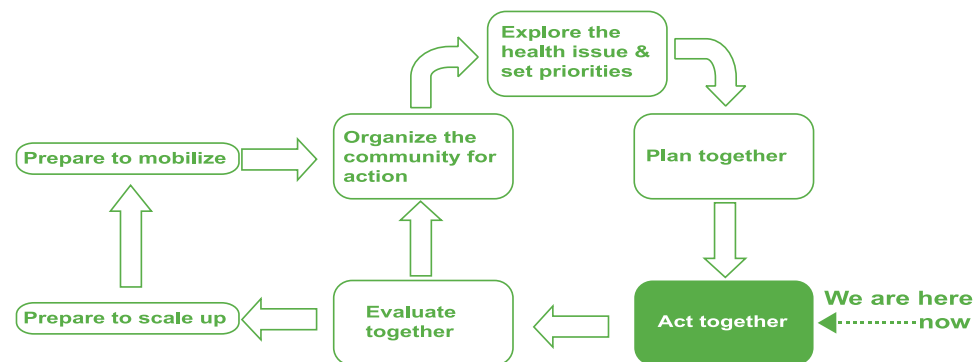
- Bhattacharyya, K. and J. Murray. (1998). "Helping Health Workers to Plan with Communities in Ethiopia and Zambia." *PLA Notes* No. 32: 4-8. London: International Institute for Environment and Development. .
- . (1999). *Participatory Community Planning for Child Health: Implementation Guidelines*. Arlington, VA: USAID/BASICS Project.
- Fox, H. (1989). *Nonformal Education Manual*. Washington, DC: Peace Corps/Information Collection and Exchange, #M0042.
- Hope, A. and S. Timmel. (1984). *Training for Transformation: A Handbook for Community Workers, Book 3*. Gweru, Zimbabwe: Mambo Press.
- Howard-Grabman, L. (1996). "Planning together: developing community plans to address priority maternal and neonatal health problems in rural Bolivia". In K. Koning and M. Martin (eds.), *Participatory Research in Health: Issues and Experiences*. London: Zed Books.
- Peace Corps. (1993). *The Design and Management of Community Projects: A Team Approach*, Washington, DC: Peace Corps/Information Collection and Exchange, #R0081.
- Rietbergen-McCracken, J. and D. Narayan. (1998). *Participation & Social Assessment*. Washington, DC: The World Bank.
- Stringer, E.T. (1996). *Action Research: A Handbook for Practitioners*, Thousand Oaks, CA: Sage Publications.
- The Institute of Cultural Affairs. (1994). *Technology of Participation Focusing Collective Power for Change: Group Facilitation Methods*, Phoenix, AZ: The Institute of Cultural Affairs.



# Chapter 5

## Act Together

1. Define your team's role in accompanying community action
2. Strengthen the community's capacity to carry out its action plan
3. Monitor community progress
4. Problem-solve, troubleshoot, advise, and mediate conflicts



“There is a solution, but it is in their terms—not yours.”

Aubrey W. Williams, Professor of Anthropology  
University of Maryland

The preparations are over. The program team has worked closely with the core group and interested community members to design a detailed action plan to mobilize the community around the health issue. Now it is time to put that plan into effect and launch the community mobilization program.

The specifics of how the plan is to be carried out were decided in the planning session at the end of the last chapter, and you should assume that that plan is now being implemented as you carry out the four steps covered in this chapter. In other words, the steps presented below concern what the external program team should be doing as the core group and the community carry out the mobilization effort.

In this context, it is remarkable how after so much participatory preparation, analysis, and planning, so many program teams neglect to play a role in the actual implementation of community activities. Perhaps it is because team members believe that once a plan has been developed, it will be followed. So they turn their attention to preparing for the evaluation. And it is true that some communities are able to implement their plans with very little assistance. But this type of community is generally not the kind in which many development agencies work. In some instances, program team members quickly revert back to more traditional roles of telling community members what to do and how to do it.

Defining your team's role during the community action phase is an ongoing challenge that you will need to revisit many times. One of the best terms used to describe the program team's general role during this phase is "accompaniment." As we explore the steps to accompany community action, we will learn about ways to strengthen the community's capacity to address health and other needs.





## STEP 1: Define your team's role in accompanying community action.

In the community mobilization process, you can play many possible roles in relation to the communities where you work. These roles, originally discussed in Chapter 1, include: mobilizer, direct service provider, organizer, capacity-builder/trainer, partner, liaison, advisor, advocate, donor, and marketer.

Program teams often assume various roles that change over time as the community's needs and capacity change. How a program team perceives its role influences the way team members and community members relate to each other. A common source of conflict between communities and external organizations is their differing perspectives on what roles each is expected to play. If you are not clear yourself about your role, you will not be able to explain why you act the way you do.

You will need to continually review your role as you move through the various phases of the community action cycle and ask yourself whether you are creating or reinforcing dependency or fostering autonomy.<sup>1</sup> (See Useful Tool I.)

### ETHIOPIA: Changing Roles

Save the Children had been directly implementing health programs in the same communities in Ethiopia for twelve years. Program staff delivered medicines to the health posts, helped with vaccination campaigns and facilitated training and health education sessions for health committees, traditional birth attendants and other groups. SC had worked with community organizations and district health services but had not helped these organizations develop their capacity to assume implementing and training roles. In essence, SC staff members were primarily acting as direct service providers. The health program donor warned that it would soon withdraw its funding as it had already invested in the program for many years. SC staff quickly needed to determine how they could best phase out of the program. SC asked local NGOs and the district health service if they would become partners, though less than a year of funding support remained.



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<sup>1</sup> In the past, many community development workers aimed to promote community self-reliance, assuming that ultimately communities could provide for all their needs without relying on external resources. We prefer the term "autonomy," recognizing that communities can and do benefit from their relationships with external resources.

**You may want to take stock of your team's strengths and weaknesses before you make any promises of technical assistance.**

## STEP 2: Strengthen the community's capacity to carry out its action plan.

During the preparation, exploration, and priority setting phases, you learned about community history, how groups and organizations function and relate to each other, how community members perceive the CM health issue, and what they currently do to improve their health. You observed how they worked in groups and were able to discern their skill levels in a number of areas. At the end of the Plan Together phase (Chapter 4), participants identified desired results and actions to achieve them.

Now it's time to review their needs with participants and determine whether and how your team can help community groups strengthen their abilities or help identify other individuals and organizations that would assist. In this context, you may want to take stock of your team's strengths and weaknesses before you make any promises of technical assistance.

The kind of assistance and expertise the community will need to increase its capacity vis-à-vis its action plan will depend on what that plan consists of. The following table lists a few examples of actions that communities often propose to improve health and the corresponding knowledge and skills needed by community members to successfully carry out the particular action.

Your team can develop a similar table with community groups to identify where participants believe they need assistance. Once you and your team have a sense of what skills and knowledge the community may need, you will have to answer three related questions: (1) *whether* you will provide the necessary assistance and, if so, (2) *how much*, and (3) *what kind*. Your answers here will be affected by many factors, which vary according to circumstances. Here are some useful criteria to help guide you in making this decision:





## Assessing the Community's Needs



- Are there other resources in the community that can meet the current needs?
- Does our team possess the necessary expertise? What are the short- and long-term pros and cons of us providing this assistance?
- Are there other accessible external resources with the required expertise? What are the short- and long-term pros and cons of inviting these individuals or organizations to assist?
- What would happen if no one provided assistance?

Keep in mind that not every effort will succeed and that some of the most important and valuable learning comes from mistakes or failed efforts. While this is sometimes painful to live through, the experience can ultimately be very positive.



You can use the Capacity Building Worksheet presented in the Useful Tools section at the end of this chapter to help you organize your information. This worksheet can then serve as a tool to help participants and your team monitor progress.

Proposed Action	Knowledge and skills needed to implement the proposed action
Establish and maintain a drug revolving fund	<ul style="list-style-type: none"> <li>- Logistics management of commodities</li> <li>- Basic accounting</li> <li>- Numeracy and literacy</li> <li>- Links to external supply sources</li> <li>- Money management</li> </ul>
Conduct a public awareness raising campaign	<ul style="list-style-type: none"> <li>- Formative research skills</li> <li>- Communication strategy/planning and technical skills</li> <li>- Knowledge of local media channels and methods</li> <li>- Monitoring and evaluation skills</li> <li>- Ability to budget, leverage and monitor resources</li> </ul>
Establish support groups, women's groups, health committees	<ul style="list-style-type: none"> <li>- Organizational development skills</li> <li>- Leadership skills</li> <li>- Technical content (knowledge of current relevant health research, recommendations)</li> <li>- Ability to link groups to external resources (as needed)</li> </ul>
Improve health facility infrastructure	<ul style="list-style-type: none"> <li>- Physical space design</li> <li>- Construction skills (e.g., carpentry, masonry, painting, plumbing, electricity)</li> <li>- Ability to leverage necessary resources</li> </ul>
Improve transport systems by establishing emergency funds, install communication systems (radios), and establish linkages with local transport workers	<ul style="list-style-type: none"> <li>- Negotiation skills (e.g., contract with transport workers)</li> <li>- Ability to leverage resources</li> <li>- Equipment maintenance skills</li> <li>- Management/operations skills</li> <li>- Logistics</li> <li>- Ability to coordinate/link various levels of referral system</li> </ul>
Prepare and distribute home care materials (clean birth kit, ORS packets, impregnated bed nets, and other products)	<ul style="list-style-type: none"> <li>- Research and product development skills</li> <li>- Ability to leverage resources</li> <li>- Marketing skills</li> <li>- Distribution skills and/or links to distributors</li> <li>- Production skills</li> <li>- Money management</li> </ul>

## Health education: a dialogue of knowledge

Regardless of the CM program, one capacity building task that often falls to the program team is to do some kind of “health education,” whether for the core group, for others on the mobilization team, or for members of the community in general. People want to learn more about the health issue, more about strategies, or more about better health practices. And the program team can certainly play an important role and provide an important service in this regard.

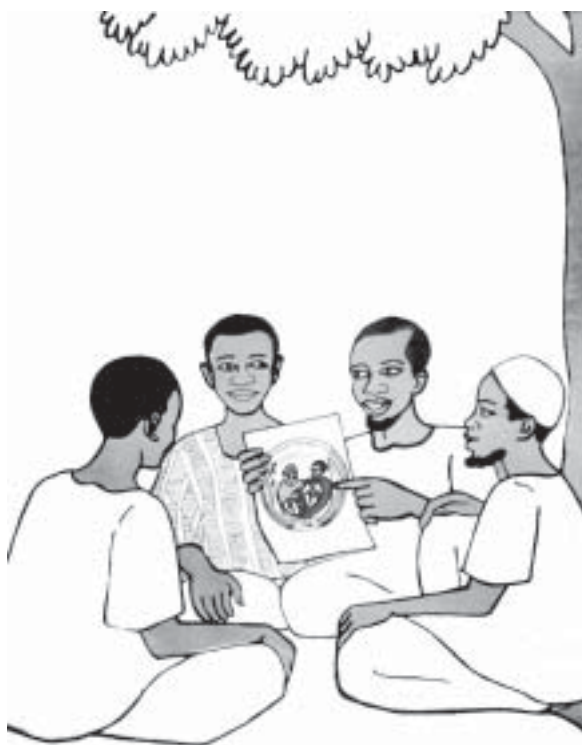
But you and your team should give some thought to how you respond to requests for health education. A natural reaction for health professionals is to revert to the didactic style, a top-down, one-directional approach where health professionals determine what individuals, groups and communities should learn and do, and then explain the “right” way to do these things.

But it may be useful to approach health education more as a dialogue of knowledge, a two-way conversation in which both parties have something to contribute. Community members also have important health knowledge, especially about local conditions and practices. Rather than repeat generic messages in “health talks” that community members may privately reject, the program team should strive to create a climate and a forum wherein everyone can educate everyone else.

A general guide to facilitating a dialogue of knowledge is presented as Useful Tool II at the end of this chapter.

### STEP 3: Monitor community progress.

Monitoring during the Act Together phase is carried out by various actors on several levels using a combination of formal and informal systems, methods, and tools.



First, let's consider some general monitoring questions appropriate for any group:

- What is our goal? What are our “desired results”?
- How do we currently assess how we are doing related to this goal and our desired results? What formal and informal monitoring processes currently exist to share observations about progress (e.g., monthly community meetings, neighbors meeting at the water pump talking about how things have changed)?
- What indicators do we use to judge our progress, success, or failure?
- What do we want to monitor that we currently do not monitor and how will we do this? What kind of tool and/or process do we need to implement?



**It is important to remember that there is always a base of experience upon which to build, and, as with all participatory processes, you need to start from where people are.**

Now, let's look at the different monitoring needs for the major groups involved in most community mobilization programs. You may need to add or omit groups to suit your program. Specific monitoring tools will need to be tailored to your particular health issue and community capacity building goals. This section provides some examples of systems, methods, and tools to monitor progress at each of these levels. It is important to remember that there is always a base of experience upon which to build, and, as with all participatory processes, you need to start from where people are.

### **Individual and family monitoring**

Individuals and families monitor their personal health progress, noting how often they are sick and how much they spend on health and illness, and by using individual and family level tools such as growth monitoring charts, vaccination cards, family wall charts, medical records, and other tools. Many programs work with community members to develop appropriate materials to enable individuals to monitor their health status.

For example, the *Warmi* Project team worked with women's groups to develop a women's health card that served both as a tool to record information related to a woman's reproductive health and to teach women about danger signs during pregnancy, delivery, and after delivery. Another example comes from



## BOLIVIA: Negotiating “New and Improved” Health Practices

During the community planning process of the *Warmi* Project, community members expressed their desire to have other educational materials on maternal and perinatal health that they could use in women’s and other literacy groups. As few materials existed at that time, a local NGO was identified to work with the women’s groups and newly identified and trained lay midwives to develop materials. The midwives wanted to have a reference book, and the women’s groups decided on a series of four short booklets on prenatal care, labor and delivery, attention to the newborn, and post-partum care.

Project facilitators supported the project philosophy and began by holding discussions with several women’s groups in each of the three geographic zones to identify the objectives of the materials. They then worked with the midwives and women’s groups to develop the content, beginning with how women viewed their bodies and reproductive functioning, current practices, and beliefs. For each module, facilitators listened to the women and midwives and then shared the current recommendations from the Ministry of Health, using terms that the participants understood and introducing medical terms with their definitions. The facilitators and the women’s group participants discussed each of the current and recommended practices. When they were different, participants discussed the feasibility and desirability of adopting the recommended practice from their perspective. The women accepted many of the recommended practices and debated others. Traditional helpful and benign practices were included in the educational materials. The group discussed traditional practices that were known to be harmful or potentially harmful and they agreed upon “new, improved practices”.

For example, women greatly feared that the placenta would rise after the baby was delivered and could suffocate or cause other harm to them. They recognized that a retained placenta could be dangerous, and believed that there are appropriate times during a reproductive cycle when organs should rise and fall. They also believed that the placenta housed one of the baby’s souls, and until the placenta was delivered, the baby was not truly born. Several practices resulted from these beliefs. When the placenta was retained, women would tie one end of a string to the severed umbilical cord and the other to their big toe to anchor the placenta so that it wouldn’t wander. Problems occurred when the string was short and the woman moved her leg, provoking hemorrhage. Some women did not want to give up the practice entirely, but agreed to make the string longer and ensure that it was clean.

Understanding these beliefs helped during the discussion about immediate breastfeeding. Instead of focusing on the previously repeated but ineffective messages about immediate breastfeeding (that it helps to inoculate the baby, its first vaccine), the facilitators presented the advantage that immediate breastfeeding causes the uterus to contract, thereby helping the placenta to be delivered more rapidly. This information was important for the women— it fit within their experience, responded to their need to ensure rapid exit of the placenta, and respected their perspective. Ultimately, many women changed the previous practice of waiting two or three days to breastfeed when their “good” milk came in to immediate breastfeeding within one hour of delivery.

*Save the Children Federation (US), Bolivia field office and Center for Interdisciplinary Community Studies (CIEC)*



Act together

the Philippines Appreciative Community Mobilization project where the team developed women's and couple's Action Cards that were used to help individuals and couples articulate their reproductive health intentions for the coming year and monitor their progress toward their goals.

Often materials such as child growth and vaccination cards are already available nationally, but may need to be adapted to suit local conditions. It is important to discuss with community members and service providers who maintain and have access to these records how they are being used to determine whether they actually meet individual and family needs for information.

### Community and group monitoring

Community groups and organizations monitor progress on action plans, including whether they are carrying out what they planned and how their efforts are affecting health and other desired outcomes. They may use checklists and conduct regular (e.g., monthly or quarterly) reviews of their action plans to determine the status of their activities. (See "Monitoring Matrix," page 153.) Monitoring activities alone is not sufficient; to ensure that activities are contributing to positive changes in health, groups also need to monitor health indicators related to the health goal. To do this, they can review information on health status (e.g., service records, health promoter reports, periodic surveys, or other surveillance systems). An example of a Bolivian community-based health information system is presented in the box on page 165. Communities may also monitor how they generate and manage resources (e.g., budget monitoring, inventory lists), the relationships that they have established with others, and how they are structured and function as a group.

Many monitoring tools, written materials, and other resources are available to community groups. Your team should help these groups identify whether and how they could benefit from using them and adapt them as necessary. As always, you will need to work with communities to prioritize where they would like to

**The more systematic community groups can make monitoring, the better they will be able to observe change or lack of change and make timely adjustments in their strategies as necessary.**

focus and tailor your assistance to meet these needs first. Most importantly, monitoring should be integrated into the Act Together phase from the beginning and occur regularly throughout the program. The more systematic community groups can make monitoring, the better they will be able to observe change or lack of change and make timely adjustments in their strategies as necessary.

### **Program team monitoring**

The program team monitors the overall program, including progress on health, community capacity, and process indicators and its own performance to inform team building and program learning.

To monitor progress on health status, your team may use the same types of monitoring tools as used by community groups (service statistics, community-based health information systems, such as SECI, periodic surveys, and other surveillance systems). It is not sufficient to merely collect the data; the *whole team* needs to review, analyze, and discuss the information on a regular basis. Depending on your particular circumstances, you may decide that monthly, bi-monthly or quarterly reviews are reasonable. Some information may only make sense to collect every six months or annually (e.g., household surveys), and this information can be incorporated into the regular review meeting.

You will need to decide whether you will do joint reviews with community groups or whether you will do an internal program team review and then accompany community groups in their own analysis. Regardless of who participates, you will need to determine the range of participants' knowledge and skills related to numeracy concepts (percentages, denominators, and other basic statistics) and how participants interpret information. Can they understand pie charts, bar graphs or other types of presentation? Don't assume that everyone has these skills. Experience suggests that many field workers, even those with high school and university education, may not have a good understanding of these concepts. They may feel embarrassed and try to hide their confusion. A basic math class for everyone may be a good investment for your team if this is your situation. Even if some members







have no problems with math, they can benefit from the course by learning appropriate ways to introduce these concepts in communities where project participants are grappling with quantitative information.

In addition to monitoring change over time, you should also monitor the types of assistance that community groups may need in the future and prepare your team to be able to provide this assistance or identify other possible sources of help if you cannot, or choose not, to provide the assistance yourself. As your team members gain experience, they will often be able to spot potential challenges that communities may face or be able to identify current issues that are blocking progress that those most closely involved may not yet be able to see.

Similarly, your own team may deal with many of the same issues that are blocking the community's progress. You will need to identify these issues and address them with your team internally. For example, after a year of project implementation, it became clear to program managers that the *Warmi* project team was experiencing many of the same gender issues internally as were evident in the communities with which they worked. Rather than ignore the issues, the program managers believed that the team was strong enough at that point to deal with some of them. They held a workshop that looked at how gender relations affected the effectiveness of teamwork. Team members identified specific instances in which these issues hindered progress or strained working relationships, and team members came up with their own proposed strategies and solutions. Over the next six months, the team implemented its strategies and then reviewed its progress. This intervention significantly improved team

## **BOLIVIA: Using Health Information to Catalyze Action and Monitor Progress**

A community health information system, SECI, consolidates primary health care data collected by community health promoters and health service providers, using simple forms and community maps. The methodology facilitates increased communication between communities and health service providers, initially by bringing promoters and service providers, together to consolidate the data. They then present the data in easy-to-understand graphics to the community so that together they can obtain and analyze new information about community health problems and articulate health priorities that reflect the community's perspective. The methodology builds in a series of analytic questions and ways to present the data, so that community members and service providers can compare trends over time, monitor progress, and determine where alternative strategies are needed. Community representatives share the consolidated information, plans, and strategies that have been developed and other results of these community meetings at district level meetings. As changes are implemented, the health information system helps the communities and health staffers work together to monitor progress toward achievement of agreed-upon objectives and make decisions on municipal and community resource allocation.

Working with district, regional and national Ministry of Health officials, the SECI program team developed and field tested the components of the health system, including a manual, health problem picture cards, and pictorial ways of presenting quantitative information to literate and illiterate community members. The team also worked with local partners at the national, regional, district, and community level to develop a complementary software package. The software package consolidates community level data from health promoters with national health information system service-based data and translates this more complete epidemiological picture into graphics that can be used with communities. Designed to be fun to use, the software package helps service providers at the district level analyze the data to help them plan program strategies.

SECI meetings stimulated joint community and service provider action that led to a number of significant achievements to improve health services.

*JHU/PCS4 Project, Save the Children Federation (US), Bolivia field office and District Ministry of Health Team*

**It is very important to celebrate these successes with communities. Each success, however small, contributes to a growing sense of confidence and accomplishment and motivates participants to continue their efforts.**



members' attitudes and behavior toward each other and strengthened team effectiveness. It also affected how they worked with community groups on these same issues, issues that were key to improving women's status and ultimately reducing maternal mortality, the project's goal.

Monitoring changes in the key underlying themes (sometimes also thought of as process outcomes), such as power relationships, gender, autonomy, shared responsibility, and quality, usually tends to be a more qualitative exercise. Generally, this type of information can be collected through transcripts or notes from community meetings, field worker diaries, in-depth interviews with participants and non-participants, periodic use of the "community history" technique, and a number of other participatory techniques such as socio-dramas, drawing and dialogue, storytelling, or puppet shows. The *Puentes* (Bridges) project videotaped most community meetings throughout its implementation. An anthropologist reviewed all of the tapes and transcripts and analyzed them, noting the evolution of dialogue between service providers and community members related to the underlying themes (see the project design example at the end of Chapter 1). This analysis was used to document changes over the life of the project related to these themes and helped the project team identify areas for further exploration during the Evaluate Together phase.

In addition to identifying areas in need of attention or adjustment, monitoring also identifies successes. It is very important to celebrate these successes with communities. Each success, however small, contributes to a growing sense of confidence and accomplishment and motivates participants to continue their efforts. Furthermore, successes often point to areas in which community group capacity is being strengthened. Refer back to your community capacity-building plans developed earlier in this chapter to document progress and propose new objectives if participants want to do so.



Finally, as with any program, your team will also need to monitor the overall management of program activities, including budget versus expenses, work plans, personnel performance and staff development, reporting to donors, relations with partners, management of logistics, and program resources.

### Donor and stakeholder monitoring

Donors or other stakeholders monitor results to account for their investments and inform future decision-making. Donors will generally require some form of program and financial report from your team to keep them informed of program progress. They will usually provide the format. Your team should make sure that you understand what the donors want to see in the reports and how they want to see it. If you know that you will have difficulty collecting some of the information on a regular basis, discuss this with your donor to determine how you should proceed.

Because community mobilization programs by their nature tend to evolve slowly, donors may need extra assurance that programs are on track. It usually helps to involve donors through field visits or other means so that they can observe the process. If a field visit is not possible, a video or visit from program participants to the donor may be helpful. This approach is particularly important if the donors involved have never experienced community work and have relatively little or no day-to-day contact with marginalized or disadvantaged community groups and the context in which they live.

### STEP 4: Problem-solve, troubleshoot, advise and mediate conflicts.

In spite of the best planning, forethought, and intentions, things do not always proceed smoothly. Difficulties may occur for many reasons which may be within or beyond a program or community's control. As important as it is to assist communities at appropriate times to cope with these difficulties, it is even more

**Each difficulty that communities encounter is an opportunity to challenge themselves, learn something new, build skills and capacity, and create new solutions.**

important to know when to stay away and let communities solve problems on their own. In other words, each difficulty that communities encounter is an opportunity to challenge themselves, learn something new, build skills and capacity, and create new solutions.

In general, it is best to let communities identify and deal with their problems on their own. There are some times, however, when you may want or need to intervene, such as when the problem:

- Directly affects your organization, team, or individual team members.
- Concerns mismanagement or misappropriation of program resources.
- Is major and is not identified by the community, possibly because the problem originates from outside of the community, such as a donor withdrawing funding for the project or a major upcoming change in public health policy that will have important repercussions on implementation.
- Concerns major differences of participants' opinion on strategy that could benefit from outside mediation and/or additional information or experience.
- Concerns important ethical issues that your organization or team cannot or will not support and that ultimately could jeopardize the overall program (e.g., coercion or violence to force compliance).

How you intervene in these cases will depend on the role(s) that you want to play in relation to the community, your organizational responsibilities, and your overall approach to the program.

Good monitoring systems and regular communication will help alert participants to existing or potential problems. When community groups identify problems through their own monitoring efforts or when others bring them to their attention, they make a decision, consciously or unconsciously, to deal with them or not. Some problems may be beyond the participants' control, and the best they will be able to do is determine how they need to react or adjust their plans accordingly. Other problems may be more directly under their control or influence, and they will need to decide what they want to do. To help communities find their own solutions, you may want to try techniques such as the Margolis Wheel described



in Useful Tool IV at the end of this chapter. For additional problem-solving techniques and approaches, you may want to explore the literature on brainstorming, lateral thinking, mind-mapping, breakthrough thinking, and other related resources about techniques used by learning organizations.



## Dealing with conflict

Clearly, it's best to prevent conflict as much as possible, through open communication, focusing on shared goals and promoting team building with a respect for differences of opinion. However, conflict within a community group or between community groups and others does happen and can be very healthy and natural for a group, as we saw with the "storming" phase of group development in Chapter 2.

Every culture has developed strategies to avoid and resolve conflicts. Some strategies, while they may resolve conflict, can also create ongoing negative feelings and resentment. These types of strategies can usually be characterized as "win/lose." "Win/win" strategies more often result in better long-term relationships, and while it isn't always possible to arrive at "win/win" solutions, it is usually worth the effort to try. It can be helpful to discuss with community groups how they have dealt with differences of opinion and conflict in the past, the results of these strategies, and the differences between win/lose and win/win approaches to conflict resolution. Community groups can establish mechanisms to help deal with conflicts when they arise, based on their most effective experiences resolving conflict or trying new approaches that incorporate a win/win philosophy.

The conflict resolution field is large and growing, with many tools, methods and techniques. (The Conflict Research Consortium of the University of Colorado has developed many tools and resources on preventing and resolving conflict.)<sup>2</sup> You will need to work with your team and community members to determine which are the most appropriate for your cultural setting and the particular issues you are facing.

<sup>2</sup>For more information, contact The Conflict Research Consortium, University of Colorado International Online Training Program on Intractable Conflict: Conflict Management and Constructive Confrontation: A Guide to Theory and Practice ([www.colorado.edu/conflict/peace/](http://www.colorado.edu/conflict/peace/)) supported by the United States Institute of Peace and the William and Flora Hewlett Foundation.

**Conflict within a community group or between community groups and others does happen and can be very healthy and natural for a group.**

Many communities will rely on existing systems to lodge their complaints. For example, community members may consult village elders to determine what should be done. Other communities decide to establish councils or committees to deal with disputes or complaints. These committees are often composed of individuals who may be elected or appointed by community members to represent a variety of perspectives and interests. These committees usually establish operating procedures so that everyone knows how and to whom disputes or conflicts should be presented and how particular issues will be resolved. To avoid additional future conflicts, these processes should be transparent to all concerned. While not everyone may agree with a decision, it should be clear how and why the decision was made.

### Troubleshooting

This section presents some of the more common problems that may arise during a community mobilization program and some questions and approaches that your team may consider in dealing with these problems should they arise.



1. An individual or group tries to block actions, usually because action threatens this individual or group's power or interests.
  - Did you involve this individual or group in the Plan Together phase? Did he/she/they agree to the plan?
  - Do you know why they are blocking the action?
  - Can participants and the group work together to negotiate a solution?
  - Can participants think of alternative actions that might be more acceptable to the group and also acceptable to participants?
2. The community does not have sufficient capacity to carry out the action.
  - Did you create a capacity-building plan with the community?
  - Is the action not feasible? Reformulate strategy/action.



3. A proposed action does not improve health status.
  - Have you allowed enough time for observable effects to occur?
  - Review the health problem and what is known about causes and potential solutions. Reformulate strategy/action.
  
4. Participants lose interest in the program.
  - Are they frustrated because they aren't seeing results?
    - Make sure that your monitoring system identifies successes and celebrates them.
    - Review actions and identify why results are not positive. Reformulate plan.
    - Review community history and identify times when the community faced difficult challenges. What strengths pulled them through? What can they build on now to maintain their motivation and energy?
    - Take a break. Let people rest and reflect on their experience, then call a new meeting to see what everyone wants to do.
  - Have competing interests or needs overtaken their desire to participate in the program?
    - Is there another specific health or other issue that participants want to address? Determine what participants want to focus on and decide how they want to proceed and whether your team is in a position to assist.
    - Often agricultural calendars or other community events may decrease participation at certain times. Know the community calendar and identify times that are optimal for program work.
    - Work with a smaller group, those most committed. These smaller groups can often be quite effective.
    - Suspend activities for a determined period and then start up again.
  
5. External project funding is diminished or cut altogether.
  - Have you explained to the donor what possible repercussions may result from the unplanned cessation of funding (such as loss of community trust, interrupted activities, broken agreements)?



**Review community history and identify times when the community faced difficult challenges. What strengths pulled them through? What can they build on now to maintain their motivation and energy?**

- Are there other alternative funding and technical assistance sources available? How can communities access these resources?
- What activities could continue without donor funded support? (Ideally, most of the planned activities would not require much external support so that communities could continue with their plans, possibly at a slower pace.) Work with the community to develop a revised plan based on this new development.

6. Communities want to engage in activities that do not directly or indirectly contribute to the health goal.

- Encourage communities to pursue their dreams.
- Determine what your team's position is on providing assistance in this case. It is okay to acknowledge that the proposed activity is an important one but that you do not possess the resources or mandate to assist with that particular project.
- Help link the community with other organizations that may be interested in the proposed activity, if any exist.
- Point out to communities the skills that they may be learning through the health program that they may transfer to their own initiatives.

7. Other organizations compete for community participation by offering incentives and other "perks":

- Discuss concepts of sustainability, voluntary participation, and community autonomy with participants.
- Continue to work with those who are truly interested in the issue, even if the group size diminishes.
- Don't respond by offering better incentives! When the incentives go, so will the participation of those who don't really support the issue.



# Useful Tools

## I. Reassessing the Program Team's Role in Community Capacity Building (Step 1, page 157)

**Purpose:** This two-part activity will help the program team members identify what roles they currently play in the community mobilization effort and what roles they want to play in the future as the project evolves. Before you begin, make two originals of the chart below: one should be titled Current Roles and the second should be titled Desired Future Roles. Then make copies of each one for each team member.

Current Roles	TM1	TM2	TM3	TM4	TM5	TOTAL
<b>Mobilizer</b>						
<b>Direct service provider</b>						
<b>Organizer</b>						
<b>Capacity-BUILDER/Trainer</b>						
<b>Partner</b>						
<b>Liaison ("Linker")</b>						
<b>Advisor</b>						
<b>Advocate</b>						
<b>Donor</b>						
<b>Marketer</b>						
<b>Other: _____</b>						
<b>TOTALS</b>	100%	100%	100%	100%	100%	100%





**Instructions:** Give each team member a copy of the Current Roles chart and have them fill it out. Ask them to look at the list of roles in the chart below (and the definitions for each role on page 30 of Chapter 1) and estimate the proportion of their time that they dedicate to each of the roles in relation to this community mobilization effort. For example, one person might say that she spends 40% of the time she devotes to this effort as an organizer, 30% as a mobilizer, 10% as a trainer/capacity builder, and 20% as an advocate. The (vertical) total for each person should add up to one hundred (100). When all team members have completed the exercise, tabulate the results and divide by the number of team members to obtain a team average. (Note: “TM1” stands for “team member #1.”)

When you have completed your tabulations, you may want to discuss the results and implications with your team. Here are some possible discussion questions:



- Which role does the team collectively spend most of its time on (horizontal total)? Why?
- How are roles distributed among team members (highly specialized, with each person playing one or two roles, or more evenly shared, with everyone performing a mix of roles)?
- How do you feel about this distribution? Is anything particularly surprising?
- Do team members’ roles play to their strengths and experience?
- Is this distribution of roles what team members prefer?
- Does this distribution of roles meet current community needs? Why or why not?

Now think about the future, using the Desired Future Roles chart. What roles in the community mobilization process will your team play in the future? How do you think community capacity will change? How can you help to support growth in community capacity? After you think about these questions, ask the team to complete the same exercise as before, but thinking about what they would like their roles to be next year. Then tabulate the results.

Once again, after you have completed your calculations, you will want to discuss the results with your team.



- How different are the results from this exercise as compared to the previous exercise? Why?
- Are team members comfortable with the general direction of the shift in team roles? Why or why not?
- What roles does the team want to play next year? Why?
- What are the implications of these results? What will team members need to do to make this happen (if that's what they want)?



## II. General Guide to Facilitating a Dialogue of Knowledge

### (Step 2, page 160)

The following is a general guide to help your team shift its role from the more traditional approach of information “dumping” to a dialogue of knowledge. This guide will need to be adapted for specific topics. In general, a dialogue process could look like the following:

- Introduction of the topic.
- Identifying with the topic. Have I heard of the topic? How do I feel about it? Facilitators can do this by projecting emotions onto another person who is experiencing the health problem if the topic is too sensitive to discuss in relation to participants’ own experiences. For example, show a picture card of a woman who is happy with a healthy child at her side and ask participants what they see? Why is the woman happy? How does it feel to be a parent with a healthy child? Show another picture of a woman with a sick child. What do you see? Why is the woman sad? How does it feel to be a parent when your child is sick? How does a sick child affect the family?
- What do we call this in local language? Slang? What do doctors call it?
- Why does this sickness/condition/practice occur?
- Can people die from it? Do people suffer for a long time because of it?
- What do we do to treat this problem? How successful is this treatment? Why do we treat it this way?



- How do we try to prevent it? How successful are we at preventing the sickness? Death or long-term problems?
- What is being recommended by the doctors, the MOH, research, experience in other countries? Why?
- How successful have people been in preventing long-term problems and death when they follow these recommendations?
- Are there similarities in what the research and doctors recommend to what we in the community are now doing? What is different? Why do we think there are these different opinions about what to do?
- Are there things that we can do differently to improve our health? Are there things that doctors or other health workers can do differently to help us? What are they? Why should they be done?
- Given what we have discussed, what more do we need to learn about? How will we learn about this?
- How can we determine whether what we are doing to improve our health is working or not?
- What decisions have we made about what we will do to improve our health (related to this topic)? What assistance do we need to be able to do them? What skills do we need to develop to be able to do them effectively?



### III. Capacity Building Worksheet (Step 1, page 159)

Action/activity proposed (taken directly from Community Action Plans)	Knowledge and skills needed	Self-assessment of ability to carry out the action	Areas to strengthen	How will knowledge and skills be strengthened? What methods will be used? (strengthen community capacity or seek external assistance for this activity?)	Who can help build knowledge and skills? (project team, community organizations, others)





## IV. Find Solutions Together with the Margolis Wheel (Step 4, pages 168-169)

The Margolis Wheel is an activity to help participants working on similar issues develop creative solutions by consulting with their peers. It also helps to create support networks as peers learn that they can help each other come up with viable solutions. The exercise works best with a group of at least eight people who are working on similar issues or topics.

### Instructions

#### Processing Questions for the Margolis Wheel

1. How did it feel to be a “solution seeker” in this exercise?
2. How did it feel to be a “consultant”?
3. What kinds of problems did you address? What types of possible solutions did you identify?  
(Note: It can be helpful to make a list of the types of problems and the possible solutions that were suggested so that participants can learn from each other, particularly if they are faced with similar problems.)
4. Who will try something that you hadn’t thought of before doing this exercise?
5. What will you do if this strategy doesn’t work?

1. Divide participants into small groups of 4 or 5 people each. One group of 4 or 5 will sit in a circle facing out. Another group of the same number of participants will sit in a circle facing in, with each participant opposite one of the participants from the inner group. The inner circle will serve as “consultants”; the outer circle will be composed of people seeking solutions to specific problems that they have identified.
2. Each solution seeker will think of a problem s/he has experienced in implementing the action plan (e.g., community members are not interested in attending health education sessions). The solution seeker will have 2 minutes to describe the problem to the consultant sitting opposite. The consultant then has 2 minutes to respond with advice. When time is up, solution seekers stand up and move to the next chair to the right. They then repeat the process with the next consultant.
3. Continue consultations until each solution seeker has consulted with every consultant in the circle.
4. Ask participants to switch places and roles so that former consultants are now solution seekers and vice versa. Repeat steps 2 and 3.



# Resources

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- Buzan, T. and B. Buzon. (1993). *The Mind Map Book*. London: BBC Worldwide Limited.
- Conflict Research Consortium. Boulder, CO: University of Colorado website at <http://www.colorado.edu/conflict/peace>
- Gonzales, F, et al. (1999). *Sistema Epidemiologico Comunitario Integral*. Published for USAID by Save the Children/US Bolivia field office in collaboration with the Johns Hopkins University/Population Communication Services 4 Project.
- Gosling, L. (1995). *Toolkits: A Practical Guide to Assessment, Monitoring, Review and Evaluation*. *Save the Children Development Manual No. 5*. London: Save the Children/UK.
- Hammand, J. (2001). *IPPF Advocacy Guide for HIV/AIDS*. London: Terracotta Press.
- Harvard Business Review. (1999). *Harvard Business Review on Breakthrough Thinking*. Cambridge, MA: Harvard Business Review.
- Herdman, C. et al. (1998). *Advocating for Adolescent Reproductive Health in Sub-Saharan Africa*, Washington, DC: Advocates for Youth. (Available in English and French.)
- International Institute of Rural Reconstruction. (1998). *Participatory Monitoring and Evaluation: Experiences and Lessons. Workshop Proceedings*. Siland, Cavite, Philippines: International Institute of Rural Reconstruction, James Yen Center.
- Johns Hopkins University/Center for Communication Programs. *A-Frame for Advocacy* (brochure). Baltimore: JHU/CCP.
- POLICY Project. (1999). *Networking for Policy Change: An Advocacy Training Manual*. Washington, DC: CEDPA, The Futures Group International, Research Triangle Institute.

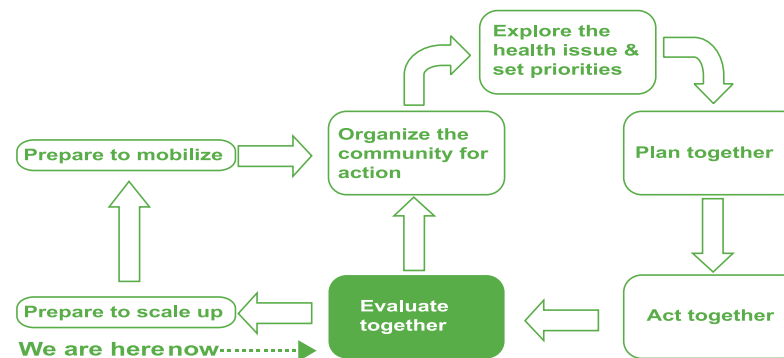
- Rietbergen-McCracken, J. and D. Narayan. (1997). *Participatory Monitoring and Evaluation: Module VI, Participatory Tools and Techniques: A Resource Kit for Participation and Social Assessment*. Washington, DC: Social Policy and Resettlement Division, Environment Department, The World Bank.
- Selener, D. et al. (1996). *Documenting, Evaluating and Learning from our Development Projects: A Participatory Systematization Workbook*, (IIRR). Ecuador: ABYA-YALA. ISBN No. 9978-04-241-5.
- Senge, P.M. (1990). *The Fifth Discipline: the Art and Practice of the Learning Organization*. New York: Bantam Doubleday Dell Publishing Group.
- Sharma, R. (1996). *An Introduction to Advocacy: Training Guide*. Washington, DC: SARA Project, Academy for Educational Development.



# Chapter 6

## Evaluate Together

1. Determine who wants to learn from the evaluation
2. Form a representative evaluation team with community members and other interested parties
3. Determine what participants want to learn from the evaluation
4. Develop an evaluation plan and evaluation instruments
5. Conduct the participatory evaluation
6. Analyze the results with the evaluation team members
7. Provide feedback to the community
8. Document and share lessons learned and recommendations for the future
9. Prepare to *reorganize*



“Project staff and evaluators often find that one of the most difficult challenges in participatory evaluation is giving up total control, or “letting go” of their notion of the right way, the right question, the right wording, the right order, the right answer.”

Deepa Narayan

Participatory evaluation creates the opportunity to focus on individual and collective learning over the life of the project. It is a time to take stock of what we have achieved, identify what has and has not worked, and make recommendations on how we can improve our efforts in the future. At first, the term “evaluation” may intimidate people; it may

evoke images of tests or examinations. Your team can help minimize any fears by involving participants in evaluation planning, implementation, and analysis while at the same time conveying an attitude of curiosity, interest, and support. It may be the first time some people have participated in a program evaluation, so it is particularly important to be sure that everyone understands the purpose of the exercise, how the evaluation will be conducted, who will be involved, and how the results will be used.

Many of the participatory evaluation techniques and tools are likely to be similar to the quantitative and qualitative tools and techniques that you used in Chapter 3 to explore the health issue. In fact, if the exploration and planning phases have been done well, the evaluation phase should be relatively easy. The emphasis in this phase, however, will be to review and reflect upon what has and has not been achieved and what we have learned. It is important to keep in mind that while you will probably be evaluating the growth in community capacity, this phase is itself a capacity-building exercise, requiring adequate attention to maximizing and building upon the experience of participants.







## STEP 1: Determine who wants to learn from the evaluation.

In determining who wants to learn from the evaluation, you should consider the many stakeholders who have been involved or have a direct interest in the project. The core group should continue to be the primary participants and should have a strong voice in the evaluation process. Other interested parties—such as the broader community, the various levels of the health system, people from the municipal/district/regional/national governments, the project team, and donors—should also be invited to participate.

There may also be people and organizations that have not been directly involved in the process but who have an interest in learning from it. Additionally, you may want to invite potential future partners to participate, to provide an external perspective and to further their understanding of the approach used and its results. (See Chapter 7, Prepare to Scale Up.)

It helps to make a list of as many of these individuals and organizations as you can think of; try to be as inclusive in your thinking as possible. Find out if these people/groups are interested in participating in the evaluation in any way. Remember that they need not be physically present to do this but can contribute questions or thoughts on areas that they are interested in learning about. Make sure you do not promise to incorporate all the questions of all the parties into the evaluation, as there will be limits on time and resources, but try to address their concerns in some way.

### PHILLIPINES: How Many is Too Many?

In Iloilo, the program team grappled with how to balance participation in the evaluation of the many actors involved in the Appreciative Community Mobilization project with practical concerns for coordination and logistics. The project was working in 16 pilot communities: 8 urban and 8 rural. Participants in the project came not only from the community, but also from the local government at the municipal level in the city or province. To ensure that all communities had some representation, the team decided on the following evaluation team composition:

- Local Government Unit health staff: 2
- Local Government Unit public officials: 2
- Barangay (community): 2-3 including Barangay Health Worker and Captain or Council member(s)
- *Sitio* (neighborhood): 2 *sitio* representatives
- SC/Philippines team: 1 for provincial sites, 1 for rural sites

The team decided that community members from one community would evaluate the progress of another community, so that they could learn from each other and at the same time strengthen ties between participating communities.

*Save the Children Federation (US), Philippines field office*

## Who Are the Stakeholders?

Individuals, groups, and organizations that might want to learn from the evaluation include:

- Community members who have participated in the project
- Community leaders
- The broader community
- The project/program team
- Donors
- Academic institutions and researchers
- Government agencies
- Organizations working on similar programs
- Policy makers
- Coalitions or networks concerned about the issue
- Private sector organizations
- Media professionals

## STEP 2: Form a representative evaluation team.

As we have seen above, many individuals and organizations may be interested in learning from an evaluation. It is obviously not practical for everyone to participate in every step of the evaluation; neither do most people feel the need or desire to do so. Creating a representative, effective, and appropriate evaluation team requires careful consideration and negotiation with all parties concerned. In some cases, donors specify who should participate in an evaluation, and their perspective should be taken into account as you put together the team.



Experienced observers debate the pros and cons of internal versus external evaluators. The table below (adapted from *Partners in Evaluation*, Feuerstein, 1986) summarizes some of the advantages and disadvantages. Because this is a participatory evaluation, internal participation is, by definition, important. However, there is also much to be gained from external perspectives and skills. If you can afford the necessary time and resources, *we strongly recommend a mix of internal and external evaluation team members.*

### A Comparison of External and Internal Evaluators<sup>1</sup>

External	Internal
Can take a fresh look at the program.	Knows the program very well.
Not personally involved, so it is easier to be objective.	Finds it hardest to be objective.
Is not part of the normal power structure.	Is part of the power and authority structure.
Gains nothing from the program, but may gain prestige from the evaluation.	May be motivated by hopes of personal gain.
Trained in evaluation methods. May have experience in other evaluations. Regarded as an expert by the program.	May not be specially trained in evaluation methods. Does not have more (or only a little more) training than others in the program.
An outsider may not understand the program or the people involved. May take a long time to read background information.	Is familiar with and understands the program and can interpret personal behavior and attitudes.
May cause anxiety as program staff and participants are not sure of his or her motives.	Known to the program, so poses no threat of anxiety or disruption. Final recommendations may appear less threatening.



<sup>1</sup> Feuerstein, M. (1986). *Partners in Evaluation: Evaluating development and community programmes with participants*, London: Macmillan, TALC.

**The larger and more diverse the team becomes, the more interesting and fruitful the process can be. It can also become more complex.**

Two additional advantages to internal evaluators are that: (1) internal evaluators are well placed to use the information from the evaluation to improve future programs; and (2) they may be more committed and interested (than external evaluators) in learning about why the program was or was not effective.<sup>2</sup>

When putting together an evaluation team, be sure to consider group dynamics, power relations, technical and interpersonal skills, credibility, diversity of strengths, weaknesses, and perspectives. Practical concerns such as potential team members' availability and logistics (e.g., transport, lodging, food, safety) also need to be considered. The larger and more diverse the team becomes, the more interesting and fruitful the process can be. It can also become more complex, and you will need to make sure that you have a team leader who is respected by team members and who has strong facilitation, management, and technical skills .

If you decide that each group to be represented on the evaluation team should select its own representative, it is helpful to discuss with these groups what will be required of their representative so they can make an informed selection. It is helpful to know such things as:

- How much time each participant will need to be available.
- Whether the participants will be expected to travel, stay overnight in other communities, need to walk long distances, and related issues.
- Whether the participant needs to be able to read and write. To enable the participation of people who may not know how to read and write, it is helpful to clarify that this is not necessary.
- A general description of what the participant will be doing.

<sup>2</sup> Bertrand J.T. and D.L. Kincaid. (1996). *Evaluating information-education-communication (IEC) programs for family planning and reproductive health*. Final report of the IEC working group (USAID Contract No. DPE-3060-C-00-1054-00). Chapel Hill, NC: University of North Carolina at Chapel Hill, Carolina Population Center [CPC], Oct. ix, 178, p. WG-IEC-03.



Teams sometimes inadvertently limit the participation of people they most want or need to include when they establish criteria that others later decide excludes that group. If you would like to ensure that women participate in the evaluation, for example, and then stipulate that participants will need to travel and be away from home for several days at a time, community leaders may decide that this makes it inappropriate for women to participate. They will likely choose men to represent the community unless you explicitly state that women need to be adequately represented. In this case, the focus shifts to which women can participate and how the family and community can support their participation. Alternatively, if communities or the women themselves do not accept some of the terms of participation, you may need to negotiate new terms (e.g., change schedules).

The process that each participating group uses to select representatives will directly influence who is chosen. Some teams prefer to let each group determine how they will select their representative. In many cases, the result is that a community leader chooses someone he or she believes would be best, whether or not this person really represents the broader group. Given the opportunity to choose, community members may support someone else's participation, someone they believe would better represent their interests and concerns on the team. The selection process is almost always fraught with difficult decisions as to how much to structure the selection versus leaving groups to set their own course. Try to anticipate what some of the difficulties may be and determine what role your team will play. In some cases, you may be able to accommodate existing selection processes (community leader-selected) with other processes (community votes or comes to consensus) by expanding the team to include more than one representative from the group. This type of compromise may help encourage greater acceptance of the evaluation results and recommendations later on.





## General Principles of Evaluation

In her book, *Evaluation: Methods for Studying Programs and Policies*, 2<sup>nd</sup> edition, Carol Weiss presents the following general principles to help evaluators maintain ethical practice:

- Honesty: don't lie about or misrepresent the evaluation to participants.
- Informed consent: people should be told enough about the evaluation that they can refuse to participate if they so choose.
- Confidentiality and anonymity: information collected from individuals should remain confidential and not disclosed beyond the evaluation team members. Any information released publicly should not mention names of respondents. Evaluators should not share responses from one individual with another respondent. Procedures should be put into place during the planning phase to protect confidentiality and anonymity (e.g., field notes should use pseudonyms or other forms of identification rather than real names, evaluation documents such as survey forms should not be left out in public places for everyone to see).
- High competence: make every effort to obtain assistance from technically competent evaluators who continually aim to upgrade their knowledge and skills [and who can share their understanding with other participants].
- Reciprocity: evaluation participants have generously offered their time to contribute to the effort. Evaluators should reciprocate by feeding back the results to these participants.

Once you have established an evaluation team, it is a good idea to agree upon ground rules or operating norms with team members so that everyone understands how the team will work together. Here are some suggestions:

- We will decide priorities based on a set of criteria established by all members of the evaluation team.
- We will be on time for meetings.
- All members will agree on who will facilitate each meeting and who will take notes before the meeting begins.
- All team members will be given the opportunity to participate in discussions but will not be forced to do so.
- When we don't understand something or need help, we will ask for help; all questions are valid.

### STEP 3: Determine what participants want to learn from the evaluation.

People involved in an evaluation usually want to learn what was achieved and what was not achieved, how, why, and at what cost. Beyond this, they may want to compare this effort with others and extract lessons to apply in the future. What the various stakeholders want to learn from an evaluation is often rooted in their roles and responsibilities in relation to the effort. For example, if you are a donor, your primary interest may be in learning whether the money that was invested was well spent—you want to see results. If you are a program manager, you want to know what contributed to success and failure and how to improve the program in the future.

Ideally, each representative on the evaluation team will have a chance to meet with his or her respective group to discuss what the group wants to learn from the

evaluation before the evaluation team develops a detailed plan, tools, and methods. Your team can support this step by making this one of the first tasks team members undertake. You may want to brainstorm with team members what questions they should ask their respective groups to elicit the groups' concerns. It may be as simple as one question, such as "What do we want to know and learn from this evaluation?" Or the team may want to explore specific areas of inquiry with their groups, such as: "What do we want to know about our capacity to improve our community's health? What do we want to know about health outcomes? What do we want to know about our other achievements? What do we need to know to improve our performance? What other aspects of our lives have been affected by our participation in this project? How?" Before going through this exercise with the evaluation team and later with their groups, it is helpful to review the project goals and objectives with the team and the group participants.

Throughout this field guide, we have discussed the importance of improving health outcomes and strengthening a community's capacity to sustain these improvements and apply what we have all learned to other aspects of our lives. With this in mind, your evaluation team may want to consider looking at outcomes in three broad categories: *health* outcomes, *social change* or community capacity outcomes, and outcomes related to *underlying health factors*. We will take up each type of outcome below.

## Health outcomes

Before you enter into the details of specific health indicators, it is important to step back and look at the big picture. What health outcomes did the project aim to achieve? What were the goals and objectives?

Then try to formulate a few key questions that will enable your evaluation to determine whether you have achieved these goals and objectives; the simpler and clearer the questions, the better. If your goal was relatively narrow, this exercise will be easier than if it was broad, as illustrated in the following example:



**Narrow Focus**    **Goal:** Reduce teen pregnancy in participating communities  
**Key question:** Has teen pregnancy been reduced during the project period of the last two years (as a result of our project's efforts)?<sup>3</sup>

**Broad Focus**    **Goal:** Improve the health and survival of children under five years old in participating communities.  
**Key questions:** Are more children under five surviving? Are children under five years old healthier now than they were when we initiated the project (as a result of our efforts)?<sup>3</sup> Note: In this case, the team would need to define what is meant by "healthier".

It is not within the scope of this field guide to review how to select health outcome indicators. But if you have done the previous phases well, you will already have established these indicators and will have been monitoring those that can be monitored on a regular basis throughout the action phase.

Evaluations can provide the opportunity and resources to collect and analyze information on those indicators that are more difficult to monitor on a regular basis. Outcomes are often compared to those of the baseline. Several resources (see the Resource Guide at the end of this field guide) catalogue the current recommended indicators in a range of health topics. Additionally, there are usually local resources on recommended health indicators available through public health institutions (Ministry or Department of Health), donor organizations, international cooperating agencies, and NGOs that you may want to consider. Keep in mind that indicators are constantly changing as the field evolves and that experts in the field may have difficulty agreeing on them.

<sup>3</sup> "As a result of our efforts" is in parentheses because your team may not have the resources or choose to do the necessary evaluation work to answer this question, as it requires comparing your communities with others that did not participate in this project or this particular approach to rule out other factors that may have contributed to improvements.





Evaluation planners need to carefully select indicators based on agreed-upon criteria such as:

- The relative value of the information to participants and other stakeholders (e.g., to justify the investment in the project, to improve program quality, to advance the field through lessons learned).
- The availability of comparable indicators from baseline assessments.
- The feasibility of gathering the data (cost, ease or difficulty of data collection, time available, skills of evaluation team members).

Many evaluators set out to assess whether a project did what the designers said it would do. Participatory project evaluation does this too, but evaluators may also need to look beyond what participants initially planned to do to determine whether project teams and participants altered their plans if they realized that a strategy was not working.

### **Social change: community capacity outcomes**

Measuring changes in community and organizational capacity is a rapidly evolving field and there are many perspectives on what things to measure and how to measure them. If your team worked earlier with the community to develop a capacity-building plan and the project has made an effort to implement this plan, then evaluating the results is a good place to start. In this case, you should consider involving project participants, other community leaders and members, and an external specialist in organizational and/or community development with a fresh perspective on the assessment of community and organizational capacity.

The Communication Initiative (Feek et al., 1999) proposed an interesting set of indicators to measure the effect of communication in social change. As adapted for this field guide, they would include such indicators as:

- Increased flow of information about the CM health issue.
- Increased public discussion of the issue.
- Increased communication between individuals and groups who have not previously worked together on this issue.
- Increased effort to include those most affected by the issue.
- Increased leadership and decision-making role by those most affected by the issue.

Building on Feeks' work, the Johns Hopkins University Center for Communication Programs<sup>4</sup> further developed the model to incorporate other indicators that reflect community level changes as a result of program efforts, such as: community leadership, degree and equity of participation during the program, shared information within the community about the health issue, collective self-efficacy to undertake other community programs, sense of ownership about program activities and results, social cohesion within the community as a result of the program, and social norms that changed as a result of the program. (Another list of indicators, grouped by the phases of the Community Action Cycle, are presented in Useful Tool I.)



### Outcomes related to underlying health factors

Throughout this manual, we have referred to underlying factors that influence the CM process and results (such as gender equity, shared responsibility, power balance or empowerment, see Chapter 1, pages 26-27 for more discussion). If you have taken the time to analyze and identify the key underlying contributing factors and have developed processes and objectives that relate to them, you should consider evaluating progress made in these areas.

Some helpful methods and tools to measure progress on underlying factors include:

- In-depth individual interviews.
- Venn diagrams that explore what it was like before the project (related to the

<sup>4</sup> Figueroa, M. L. Kincaid and G. Lewis. (2000). Working Paper supported by the Rockefeller Foundation.



underlying factor), what it is like now, and what changes the respondent attributes to the project.

- Case studies that document the evolution of the factor over the life of the project.
- Analysis of audio- and/or videotapes to track progress on dialogue related to the factors.
- Surveys (when the factor is concrete enough to lend itself to survey questions).
- Analysis of attendance lists (disaggregating participation by sex, age, or other criteria).
- Picture histories (series of pictures showing evolution over time related to the factor) or other drawings.
- Values clarification exercises at baseline and later on during evaluation phase.
- Social mapping to depict relationships before and now.
- Story telling to depict how things were before and how they are now.

## Setting priorities

It is important to review with stakeholders and the evaluation team all the topics you could potentially evaluate in order to determine priorities, since no team will be able to address all of these areas in depth.

Some questions to help you set priorities follow.

- Are there any indicators that you are required to report on by the donor, participants, or other stakeholders?
- What is the primary purpose of the evaluation? Which questions, if answered by the evaluation, would most directly relate to the primary purpose?
- What would participants be able to do or decide if you had the answer to this question?
- Would the answer to this question influence the direction of the evaluation?
- Would the answer to this question contribute to understanding in the field (beyond this project)?
- Are there sufficient resources to answer this question?



**It is important to review with stakeholders and the evaluation team all the topics you could potentially evaluate in order to determine priorities, since no team will be able to address all of these areas in depth.**

## STEP 4: Develop an evaluation plan and evaluation instruments.

Once the team and core group have identified the questions they want to ask and the indicators they will be looking at, it's time to put this information together into an evaluation plan. At a minimum, an evaluation plan should answer seven key questions, as presented in the Evaluation Plan worksheet on page 198. The seven questions are:

**1. What were the project's objectives and expected outcomes?** Here you will make a list of the overall goals and objectives of the community mobilization project and a second list of the expected outcomes.

**2. What questions do we need to ask?** This is a list of questions you will need to ask to determine what the outcomes of the project were, whether or not the project met its goal and objectives, and why or why not. Sample questions include:

- What happened?
- What elements of the project worked?
- What elements did not work?
- What were some conspicuous successes?
- What were some conspicuous failures?
- What still remains to be done?
- What is the community's vision for the future?
- How has the community's capacity grown during the project period?
- Which results obtained during the project period are likely to be sustained or improved upon?

**3. What information do we need to answer these questions?** This will be a list of the indicators you will have developed (or will now need to develop) with the help of the information in the latter half of Step 3.





**4. How will we collect this information?** This part of your plan should include a list of the instruments and methods you will be using to collect the information you've now decided you need. Some suggested methods here would include:

- Repeating the baseline survey
- Stories (peak moments, peak achievements)
- Drawings (e.g., of project history)
- Skits to present important milestones or events
- In-depth interviews with project participants and observers
- Group discussions
- Picture card pile sorts (sort interventions that worked/did not work)
- Rankings (rank initiatives/interventions from worked best to worked least)
- Review of the project proposal, reports, and documents

One of the most common ways of evaluating a project (listed first above) is to repeat the original baseline assessment to determine the extent to which key indicators may have changed. If you are repeating a baseline survey or other baseline assessment to compare pre- and post-project implementation status, you must use the same instruments and techniques that were used at baseline. You will need to determine whether you would like to repeat the exercise exactly as it was carried out before or whether you would like to add new questions. For example, the team may want to add questions when members have learned through their experience with project implementation that there are additional factors that may influence results, factors they may want to understand better or want to use as information to build upon in the future. The team might delete questions if they are no longer relevant to the program, such as a planned intervention that was never implemented.

### **BOLIVIA & PERU: Ultimate Causes**

The *Warmi* project team believed that low women's status was a large contributor to maternal mortality and morbidity. To address this issue, the project aimed to increase women's status by increasing their participation in women's groups and other community organizations. The *Warmi* project evaluation then documented the extent to which women actually did participate and whether their status was increased as a result of their participation. This document used a combination of quantitative and qualitative methods with the women themselves, men, community leaders, and health service providers. Clearly, this information is context specific and can only be understood in relative terms (what it was like before the project and what it is like now). In the case of the *Warmi* project, the team was not able to compare participating communities to nonparticipating communities, as most communities in the area participated and finding comparable nonparticipating "match" communities was difficult.

In the *Puentes* Project in Peru, *shared responsibility* was a key underlying theme. The team analyzed the transcripts from videos and meetings throughout the project to identify changes in community and service provider dialogue and action related to this and other key underlying themes.

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**5. Who will collect the information?** You will have to decide who is going to collect which information in what places. If you have already decided how the various kinds of information are going to be collected (in 4. above), using which instruments and methods, then you may want to match people up with the methods/instruments with which they are most familiar and comfortable.

**6. What resources/materials will be needed?** Make a list of who will need what in order to collect each kind of information from the various sources where it will be collected.

**7. When will this information be collected?** Create a timeline for the various participants.

With regard to assessing community capacity (one of the questions under number 2 above), you may want to use (or modify) Save the Children's community management and participation scale (Chapter 2, pages 90-96). Your team can ask participants to document or describe in some way (see number 4 above for suggestions) how the community worked in the past and how it is different now. The question can also be dealt with by referring to the community's vision of the future and discussing with participants how they plan to get there, what steps they will take, what specific experience they have had in the past that will contribute to them being able to move forward, what skills and abilities they plan to strengthen and how.

Answering these questions in a systematic and thoughtful manner should give you a basic evaluation plan that will serve as a good starting point for your efforts. As you develop this participatory evaluation plan, here are three important points to keep in mind:



- *Every team member doesn't need to do everything.* As with any team, it is important to maximize members' skills and program resources. If you have many team members, it can be counterproductive for all members to attend all evaluation activities. In most cases where group discussion is involved, for example, one or two facilitators is sufficient. For example, one person can facilitate the discussion while another observes and records information. If team members are interested in building their skills in conducting a variety of evaluation methods and techniques, they can divide up the work keeping this objective in mind.
- *Select methods, tools and techniques after evaluation questions and content are agreed upon.* Sometimes, in their zeal to try out new participatory techniques and methods, team members look for ways to include them in field work without taking the time to determine whether these particular tools or techniques would be effective to answer a particular question. Using these techniques can lead to interesting discussions, but may not ultimately help to answer priority questions that evaluation team members and the groups which they represent have set out to answer. (See next section on selecting methods and refer to the Participatory Facilitator's Guide for further assistance.)
- *Keep it simple; don't make things more complicated than they are or need to be.* It is easy to find yourself buried in pages of proposed indicators, potential methods and tools, and a variety of possible evaluation designs, so much so that some teams may forget what it was they initially had set out to learn. It helps to go back to your "burning questions" and develop a brief one- or two-page plan to which everyone can refer. Try to limit the indicators to a manageable number. Make sure that everyone on the team can explain what the evaluation is about, how it will be carried out, and what they hope to learn from it. If team members cannot describe what they will be doing, the plan is not clear enough and the team leader will need to work with team members to simplify and clarify concepts and processes.

**As with any team, it is important to maximize members' skills and program resources. If you have many team members, it can be counterproductive for all members to attend all evaluation activities.**

To facilitate data organization, the team should develop some draft analysis tables to keep track of information as it comes in so that it will be easier to analyze later on.

## EVALUATION PLAN



What are the objectives and expected outcomes?	What questions do we need to ask?	What information do we need to answer these questions?	How will we collect this information?	Who will collect the information?	What resources/materials will be needed?	When will this information be collected?



### STEP 5: Conduct the participatory evaluation.

When the team has developed the plan, methods, and instruments to collect information and has practiced using them and has worked out the logistical details (transportation, meals, accommodations, meeting places, equipment needs, communication with community participants and interviewees to set schedules), it is time for the team to conduct the evaluation.





The team leader should determine how she or he can best support the other members, identifying which subteams may need more help with certain tasks or communities, whether all teams have the materials they require, and assisting team members as needed. The team leader should ensure that the information is organized as it comes in, so that field notes, surveys, and other evaluation documents, pictures, audio tapes, and videotapes don't get lost. If you have access to a computer and to someone who knows how to set up a database, the team can enter the data into the computer to facilitate analysis. If your team has developed analysis tables as mentioned in the planning phase, the person entering data should use these tables to organize the information. If you don't have access to a computer, you can record data manually using tally sheets.

If at all possible, the team should meet every day after fieldwork has been completed. These meetings help team members to identify problems, challenges, share and consolidate learning, and make adjustments in the plan, information collection instruments, and methods if necessary. The meetings can also help to build a more cohesive team, leading to more trust and rapport in the group, helping team members to more openly communicate their thoughts and feelings about what they are learning.

More often than not, something will not go exactly as planned and the team will need to be flexible. This is to be expected. The better your team has identified its priorities and has planned alternative approaches to conduct the evaluation should problems arise, the more easily team members will be able to cope with unanticipated changes.

## BOLIVIA: Evaluating *Warmi*

The final evaluation of the *Warmi* Project included both qualitative and quantitative methods and was participatory in design, analysis, and writing. A wide range of persons played key roles in implementing the evaluation and interpreting the results, including representatives from the Ministry of Health, CARE, The Population Council, San Gabriel Foundation, Save the Children's Home Office, Save the Children/Bolivia staff and nine women representatives from communities participating in the *Warmi* Project. Emphasis on participation at all levels allowed the team to capture the explicit and implicit achievements of the program.

Using a variety of methods, the evaluation tried to consolidate the quantitative and qualitative results of the project.

**Quantitative methodology:** A retrospective case-control study (cases were maternal, perinatal, and neonatal deaths; controls were babies born in the same communities the same year that did not die) that had been done at baseline was repeated. The results from the final evaluation were compared with those of the original study in order to identify trends in the project indicators. The evaluation team reviewed the manual information system and compared the last project year's results with project goals and objectives, as well as with the results of the case-control study.

**Qualitative methodology:** Evaluation team members interviewed pregnant women, lay midwives, MOH staff at local facilities, SC/Bolivia staff, husbands, women of reproductive age and representatives from the PVO and NGO health network, PROCOSI, San Gabriel Foundation, CIEC and AYUFAM (local NGOs that had participated in the project). They also led group discussions with nine women's groups from the three project zones, midwives, and local authorities from each zone.

The evaluation team developed interview guides for all interviews. SC/Bolivia and MOH staff took a short written exam to determine their level of knowledge regarding several important indicators. The group interviews also utilized several participatory techniques, including a "pile sort" of project intervention cards in small groups, judgments of characters' actions (good, bad, don't know) in stories told by the interviewers, and drawings or written statements of the groups' vision of the future.

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## STEP 6: Analyze the results.



To begin the analysis, evaluation team members review the information collected in the field. Analysis tables such as those presented at the end of the chapter (see Useful Tool II) will help the team organize the information so that data related to the same question coming from various sources can be compared and contrasted. To help ground team meetings in real data, make copies of these tables and/or prepare flip charts of the major findings so that all group members can see them and make notes on a common draft. If there is a lot of information, the team leader may want to divide the team into subgroups to concentrate on specific questions or types of data analysis before the whole group meets together to analyze the findings.

Here are some suggested general questions to guide the analysis:

- To what extent has the project achieved its health objectives?
- To what extent has the project strengthened community capacity/ability to sustain and further improve its health and well-being?
- To what extent were process outcomes achieved?
- How much did it cost?
- What lessons have been learned? (What worked? What didn't work? What would we have done differently? What will we do in the future?)
- What questions remain to be answered?
- What new questions have emerged?
- What do we recommend to others based on this experience?

## STEP 7: Provide feedback to the community.

When the team has finished its analysis, it is important to feed the results back to the participating communities in a way that everyone can understand. The feedback session is a chance to validate the results and to raise questions that the team and the community have about them.



In preparing for the feedback session, consider the primary purposes of the session. Is the session primarily to:

- Provide information?
- Stimulate dialogue?
- Seek community insight/answers to questions?
- Advocate for some type of action?
- Provide a mechanism for feedback from the community?
- Comply with donor or other requirements?



The primary purposes of the meeting will help the team determine how best to structure the time. Team members should discuss with their respective stakeholder groups what they want from the feedback session before the team decides what the primary purposes should be. As with any community meeting, arrange the time and place with communities well in advance so that people can arrange their schedules and also to avoid conflicts with other meetings and community events. To make best use of this time with the community, the team will need to be well-prepared. Simplify the results so that the major findings are covered. You will generally not have enough time to go into the many details that may be interesting to you but may be less important to people attending the meeting. A summary report should be available for participants who would like to learn more about the evaluation.

It is easy to adopt a one-way communication style when presenting evaluation results. There is a lot of information that the team would like to communicate to its audience, and the easiest method is to tell everyone everything in a plenary session. But this approach can be tedious, particularly if the information is organized around the answers to survey questions or other evaluation tools. There are many other creative ways to share results, ways that encourage more dialogue and learning. For example:

- Simple **graphics** or other **visual tools** can help communicate the results if presented in culturally appropriate ways. It is important to pre-test graphics if you choose to use them.

- In a **gallery walk**, you can post the results on a wall using pictures such as those mentioned above and have participants walk around the room. Small groups stop at each picture and describe what they see. A facilitator from the evaluation team can explain the results in more detail and can answer questions. You may put up a blank sheet next to the result so that comments and questions can be recorded.
- Distribute **summary reports** (in writing or in pictures) to **small groups** of five or six people each. A facilitator from the evaluation team can discuss the results with his/her group and ask open-ended questions to learn about participants' reactions to the results. Participants are encouraged to ask questions and offer their opinions.
- **Skits or role plays** can announce the results in entertaining ways. For example, an evaluation team member can play a reporter giving a newscast and interview other evaluation team members and then interview the audience for its reactions.

When you have completed the feedback session, it is important to incorporate community participants' observations into the team's analysis of the results.

### Presenting disappointing results

Not all programs achieve overwhelmingly positive results. Disappointing results may occur for many reasons, some that could have been prevented and others that may have been beyond the control of program implementers. Evaluations offer the opportunity to learn about successes *and* failures. Admitting that significant effort has not led to improved health or the achievement of other stated objectives can be difficult. To overcome their disappointment, some teams try to downplay the importance of these results, blame others for the outcome, or point to technical problems in the evaluation methodology.

Rather than disown the results, it can be more instructive to look at what happened and why in order to learn from the experience. What would you do differently? What assumptions did you make that may not have held up when tested? Have other similar communities experienced even worse conditions because they



had not made the kind of effort that participating communities did? Facing “bad” results or results that may provoke conflict and being willing to learn from them is critical to moving forward. Similarly, even when results are positive, we need to understand why and how they were achieved if these results are to be sustained and similar methods and interventions are to be applied successfully in other settings.

### Take time to celebrate success

The evaluation is a time to reflect on what has been achieved. Take the time to celebrate the victories—even the smallest ones—and plan with the community to acknowledge the good work that has been done. This celebration can be in the form of having a meal together, acknowledging people’s contributions with certificates or small tokens of appreciation, or in other culturally appropriate ways.

## STEP 8: Document and share lessons learned and recommendations for the future.

One of the most difficult tasks for busy field workers to carry out is documenting what they have done and the results of their efforts, a requirement often set by donors or other stakeholders. When such requirements don’t exist, the team has even less incentive to complete project and evaluation documentation. If there is so much work to be done in the field, the logic goes, why take precious time away to document our experience and the lessons we’ve learned? In addition, many communities and organizations engaged in fieldwork undervalue their rich experience, believing that what they have learned may be obvious to others or might not be of interest to anyone else. As a result, information about many effective community-based programs never spreads beyond the local area and those who are just beginning to work in the field find relatively few documented experiences upon which to build.

**Documentation is a great opportunity to promote global sharing and learning. When you learn from your experience, you should help others learn too by documenting and disseminating your experience.**

But this dynamic is beginning to change as information technology becomes more accessible and it becomes easier to share field experiences with our colleagues, not only within the same community, district and country, but more broadly with our peers in other countries. This is a great opportunity to promote global sharing and learning.

But whom should this information be shared with and in what form? If you refer back to step 1 of this chapter, you will recall the list of stakeholders you identified who wanted to learn from this evaluation. This list is the core of your audience. In step 3, we identified what each of these audiences wanted to learn from the evaluation; using this information, you can now develop a summary of the results tailored to these groups' particular needs. If the needs are very similar, you may only have to develop one or two reports and /or presentations; if the needs are quite different, you may have to tailor your feedback to the audience. The sample documentation matrix presented below is one common way to organize this kind of information for your stakeholders (and an expanded version appears as Useful Tool III).



Stakeholder/ audience	Learning interest	Purpose of documentation/ dissemination	Material/method of dissemination
Policymakers in MOH	How MOH policies inhibit or enhance service delivery at the community level	To inform health policies	<ul style="list-style-type: none"> <li>• One-page briefing paper summary on policy implications</li> <li>• Full evaluation report with Executive Summary</li> <li>• 1.5 hour presentation of evaluation results and discussion on policy implications</li> <li>• Article published in local technical journal</li> </ul>



However you decide to proceed, it is worth discussing with your team how you would like to contribute to the greater body of knowledge and experience aimed at improving health through community mobilization and change.

### STEP 9: Prepare to reorganize.

The purpose of most evaluations is not merely to determine whether your efforts have succeeded, but also to help guide future action. If the community believes that there is still work to be done on the same issue, participants can use the results of the evaluation to determine whether they need to reorganize (as in changing the nature and structure of participation). If they determine that a new organizational structure is warranted, they may want to review the community organizing phase (Chapter 2) as they begin a new Community Action Cycle. If they believe that the individuals, groups, and organizations are structured appropriately, they may want to move on to exploring the questions about the CM health issue that emerged during the evaluation and initiate a more profound and directed inquiry. Or they may move more quickly through these two phases and on to the planning phase if they would like to apply what they have learned to developing new strategies.

If the community has made significant advances to the point that it is ready to take on a new health or other issue, or community members have decided that they would like to work on another pressing issue, it is time to return to the beginning of the Community Action Cycle.

**The purpose of most evaluations is not merely to determine whether your efforts have succeeded, but also to help guide future action.**



# Useful Tools

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## I. Criteria to Measure Community Capacity Outcomes

### (Step 3, page 192)

Using the Community Action Cycle as a frame of reference, your team can work with community groups and individuals to explore their performance during the various phases of the cycle. Examples of indicators for each phase of the cycle follow. For the indicators that mention a specific skill or ability, you may want to use a scale as part of your evaluation. A sample scale might look like this:

1. Has not demonstrated this ability.
2. Has demonstrated this ability with significant outside assistance.
3. Has demonstrated this ability with some outside assistance.
4. Has demonstrated this ability with minimal outside assistance.
5. Has demonstrated this ability with no outside assistance.

If you use this kind of scale, also consider documenting concrete examples of what the community group/organization did that demonstrates this level of ability.

### *Organize the Community for Action*

- Baseline versus current number of organizations that have demonstrated commitment to the CM health issue (e.g., number of organizations that have publicly stated that they support work on the issue and/or have taken action to address the issue).





- Composition of organizations addressing the issue: size of organizations, number, and/or percent of those affected by the issue who participate in the organization.
- Leadership.
- Structure of the organizations: representation, communication channels (e.g., demonstrated ability to establish structures that facilitate achievement of desired results).
- Shared and articulated vision of core group/organization exists, is known by members, is recognized by others outside of the group.

### **Explore the Health Issue and Set Priorities**

*Level of demonstrated ability to:*

- Openly discuss the issue with others (e.g., within a peer group, outside of an established group, in a public forum).
- Gather information about the health issue using a variety of quantitative and qualitative methods.
- Analyze information that has been gathered on the health issue to arrive at consensus on priorities.

### **Plan Together**

*Level of demonstrated ability to:*

- Use existing and new information as a basis for decision-making and planning.
- Develop desired results/objectives related to the health focus.
- Determine who needs to be involved in planning.
- Develop a planning process.
- Identify existing and needed resources.
- Identify potential barriers or challenges to achieving desired results.
- Identify various strategies to achieve desired results.
- Establish coordination mechanisms.
- Assign and accept responsibility for planned actions.
- Identify indicators of success.
- Identify areas of weakness in community capacity and strategies to strengthen them.

### **Act Together**

*Level of demonstrated ability to:*

- Leverage resources.
- Manage resources.
- Carry out action plans.
- Implement effective technical interventions.
- Advocate for policy changes.
- Monitor progress.
- Identify when planned activities or strategies are not leading toward desired results and develop alternative strategies.
- Access relevant information on “best practices,” technical recommendations.
- Communicate internally and externally.
- Coordinate/collaborate with other institutions or groups on the issue.
- Share information with others.

### **Evaluate Together**

*Level of demonstrated ability to:*

- Identify the purpose of the evaluation and key questions to address through the evaluation.
- Establish an evaluation team that is representative of stakeholders.
- Determine evaluation indicators.
- Develop an evaluation plan.
- Conduct an evaluation (qualitative and/or quantitative).
- Analyze results.
- Generate recommendations and lessons learned.
- Document and disseminate results.
- Use results for the next community action cycle.

Some of the organizational abilities mentioned above may be demonstrated in more than one phase of a program. Please note that this list is not exhaustive.



## II. Worksheet for Reporting Results

### (Step 6, page 200)

You may find this matrix helpful for organizing and reporting the results of your evaluation. (A sample from Bolivia is included on the next page.)

Desired Results (Objectives, indicators and questions related to objectives)	Actual Results (What was achieved?)	Analysis (Why? What contributed to achieving these results?)	Lessons Learned	Recommendations



Here is an example of a Results Matrix from Bolivia:

Desired Results (Objectives/ indicators questions related to objectives)	Actual Results (What was achieved?)	Analysis (Why? What contributed to achieving these results?)	Lessons Learned	Recommendations
Increased use of contraceptive methods.	Increase in use of contraceptive methods from 10% to 22% over baseline.	<ul style="list-style-type: none"> <li>• Introduction of community-based distributors increased access.</li> <li>• Improved, more consistent supply of methods when municipal officials participated in project planning and monitoring activities.</li> <li>• Increased awareness of FP methods (from 65% at baseline to 83% at final).</li> </ul>	Municipal financial and logistical support is key in maintaining steady stock of contraceptive supplies. Support increases when municipal council members are involved in health planning process.	Continue to involve municipal officials and strengthen their participation in planning and monitoring of FP and health activities.



### III. Matrix for Documenting Lessons Learned (Step 9, page 201)

#### DOCUMENTATION AND DISSEMINATION PLAN



Stakeholders/ Audience	Learning interest	Purpose of documentation/ dissemination	Material/method of dissemination	Person/team responsible	When?

# Resources

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- Adamchak, S. et al. (2000). *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs*. FOCUS on Young Adults, Tool Series 5.
- Aubel, J. (1993). *Participatory Program Evaluation*. Baltimore: Catholic Relief Services and Child Survival Technical Support/USAID.
- Chawla, S. and J. Renesch. (eds.). (1995). *Learning Organizations: Developing Cultures for Tomorrow's Workplace*. Portland, OR: Productivity Press.
- Fetterman, D. et al. (eds.). (1996). *Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability*. Thousand Oaks, CA: Sage Publications.
- Feuerstein, M. (1986). *Partners in Evaluation: evaluating development and community programmes with participants*. TALC. London: Macmillan.
- Goodman, R. et al. (1998). "Identifying and Defining the Dimensions of Community Capacity to Provide a Basis for Measurement," *Health Education and Behavior*, Vol. 25 (3):258-278.
- Gosling, L. (1995). *Toolkits: A Practical Guide to Assessment, Monitoring, Review and Evaluation*. *Save the Children Development Manual No. 5*. London: Save the Children/UK.
- International Institute of Rural Reconstruction. (1998). *Participatory Monitoring and Evaluation: Experiences and Lessons. Workshop Proceedings*. Siland, Cavite, Philippines: International Institute of Rural Reconstruction, James Yen Center.
- Narayan, D. (1993). *Participatory Evaluation: Tools for Managing Change in Water and Sanitation*. Technical Paper #207. Washington, DC: The World Bank.
- Rietbergen-McCracken, J. and D. Narayan. (1997). *Participatory Monitoring and Evaluation: Module VI, Participatory Tools and Techniques: A Resource Kit for Participation and Social Assessment*. Social Policy and Resettlement Division, Environment Department. Washington, DC: The World Bank.
- Selener, D. et al. (1996). *Documenting, Evaluating and Learning from our Development Projects: A Participatory Systematization Workbook*. IIRR. Ecuador: ABYA-YALA. ISBN No. 9978-04-241-5.
- Weiss, C.H. (1998). *Evaluation: Methods for Studying Programs and Policies*. New Jersey: Prentice-Hall.
- Wholey, J. et al. (eds.). (1994). *Handbook of Practical Program Evaluation*, San Francisco: Jossey-Bass.
- World Health Organization. (1993). *Rapid Evaluation Method Guidelines for Maternal and Child Health, Family Planning and other Health Services*. Geneva: WHO, Division of Family Health and Division of Epidemiological Surveillance and Health Situation and Trend Assessment.
- . (2000, July). "Reproductive Health Indicators for Global Monitoring." Report of the Second Interagency Meeting. Geneva: WHO.



# Chapter 7

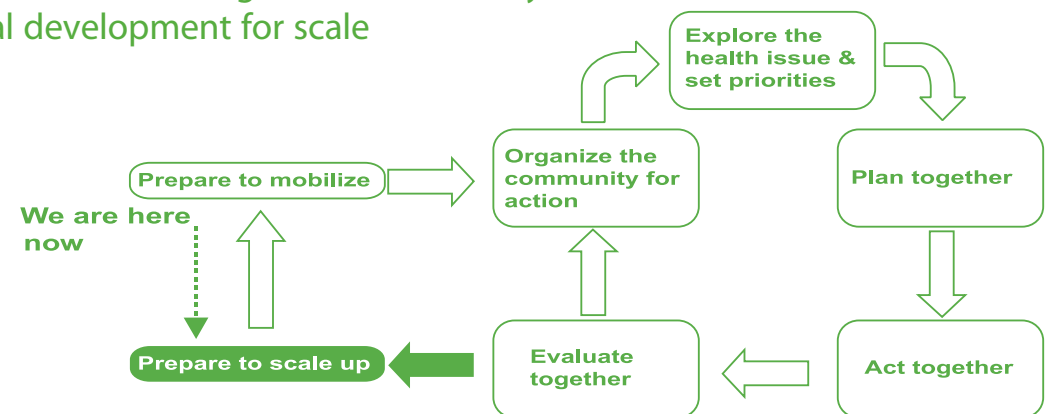
## Prepare to Scale Up

### BEFORE YOU SCALE UP...

1. Have a vision to scale up from the beginning of the project
2. Determine the effectiveness of the approach
3. Assess the potential to scale up
4. Consolidate, define, and refine the approach
5. Build a consensus to scale up
6. Advocate for supportive policies

### AS YOU SCALE UP...

7. Define the roles, relationships, and responsibilities of implementing partners
8. Secure funding and other resources
9. Develop the partners' capacity to implement the program
10. Establish and maintain a monitoring and evaluation system
11. Support institutional development for scale



“The great challenge for successful community-based demonstration projects is how to expand their reach...without compromising quality.”

Warmi case study

### What is “scaling-up”?

Scaling-up community mobilization means expanding the impact of a successful mobilization effort beyond a single or limited number of communities to the regional, national, or even multinational level. While the appeal of scaling-up is obvious, the challenge is

to do so without diminishing the quality of the original effort.

Experience over the last decade is beginning to show that community mobilization approaches *can* be scaled up. This chapter will look at some of these experiences and will lay out steps to help you scale up successful community mobilization approaches.

Programs achieve scale either by starting out at scale (or very quickly going to scale) or through incremental efforts to expand coverage.<sup>1</sup> Programs typically scale up in one of five major ways:

**Planned Expansion:** a steady process of expanding the number of sites for a particular program model once it has been pilot-tested and refined.<sup>2</sup>

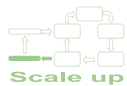
**Explosion:** sudden implementation of a large-scale program or intervention, without any cultivation of policy support or gradual organizational development prior to implementation.

**Association:** expanding program size and coverage through common efforts and alliances among a network of organizations.

**Grafting:** adding a new young adult reproductive health program, for example, to an already existing program.

<sup>1</sup> Focus on Young Adult: Getting to Scale in Young Adult Reproductive Health Programs: A Synthesis of Experience, June 1999.

<sup>2</sup> The terms expansion, explosion, and association were suggested by Myers, *The Twelve Who Survive*, p. 379.





**Diffusion:** other organizations learning about approaches through access to materials and case studies and replicating the approach.

Without significant *uptake*—the degree to which other significant development actors (e.g., NGOs, community-based groups, bilateral and multilateral agencies, host governments) adopt and adapt methodologies— scale cannot be reached. Uptake is significantly different from replication in that the former involves adaptation of strategies or methodologies to fit varying program contexts. In order to achieve substantial uptake, an organization needs to:

- Engage in experience-based advocacy.
- Garner recognition and attention for its work.
- Embrace monitoring and evaluation practices that produce credible results.
- Engage in effective networking and strategic partnering.<sup>3</sup>

## Why scale up?

Scaling-up successful community mobilization approaches offers a number of benefits. Among other things, it can:

- Extend the positive benefits of your program to more people who need and want them.
- Maximize resources and the investment made in developing the approach.
- Contribute to a growing awareness of the particular health and related issues that are of concern to the mobilization effort and help to foster changes in social norms.
- Increase support for changes in policies and resource allocation related to the issue as more communities begin to address their needs.
- Begin to address some of the underlying causes of health problems as a critical mass of people develop their knowledge and skills and build organizational linkages within and beyond individual communities.

<sup>3</sup> BREAKTHROUGHS for Children, Save the Children International Programs Department, Strategic Directions: 1999-2003.



## ECUADOR: Scaling Up a School-Based Program

A school-based sex education program was initiated as a collaboration between *Centro Medico de Orientacion y Planificacion Familiar/CEMOPLAF* (an Ecuadorian NGO) and an American university and eventually developed the support and endorsement of the government. The program went to scale by expansion, with phased replication of the initial pilot program.

The CEMOPLAF program had many reasons to believe that taking a school-based program to scale would succeed, given the following enabling factors:

1. The documented high demand for the training and curriculum on the part of teachers, parents, and students. Schools repeatedly asked CEMOPLAF staff to provide information to adolescents on reproductive biology and physiology, changes during puberty, and other related topics. As a result, CEMOPLAF conducted a needs assessment to identify the overall demand for these services and others related to meeting youth's needs. The results of this assessment were used to guide the curriculum development process.
2. The pilot project received funding and technical assistance to conduct extensive monitoring and evaluation. Feedback from all involved—the students, teacher, and parents—was effectively used to make necessary changes.
3. The partners benefited from the long-standing good relationship between CEMOPLAF and the Ministry of Education and Culture, as well as CEMOPLAF's good reputation for the provision of family planning services throughout the country.
4. The program planners collaborated closely with local schools during the pilot implementation in order to build relationships with local partners and win their trust.
5. After the success of the pilot project, the Ministry of Education and Culture officially endorsed the curriculum, which provided a strong boost for the expansion. Eventually, the collaboration led to their working together to draft legislation for the Congress for sex education in public schools.

*Focus on Young Adult: Getting to Scale in Young Adult Reproductive Health Programs: A Synthesis of Experience, June 1999.*

## Common assumptions about scaling-up

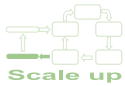
Some of the common assumptions about scaling-up are not always valid. Thus, it is worth exploring your own assumptions before you engage in this process. Some of these assumptions are:

**1. To move from your current program to scale is just a matter of expanding what you are currently doing.**

This assumption may hold true when a community mobilization approach is only expanded up to a limited point. However, most scaling-up efforts require the formation of partnerships to achieve wide coverage. When these partnerships form, you will probably need to create new management and operations systems that can continue to support the program's core values and maintain quality. Even when an organization decides to expand its efforts on its own, it needs to create new systems to support growth while maintaining quality. It's not just a matter of expanding what you are currently doing!

**2. Scale-up happens only through geographical expansion.**

Community mobilization programs may achieve wide scale impact through means other than geographic expansion. Communities participating in a



“small scale” effort may identify policy issues that need to be addressed and may effectively advocate to change them at regional and national levels, thereby creating national level impact that can have highly beneficial results for people all over the country.

With growing access to information channels such as the internet, radio, distance learning, video, television, and print media, it is becoming easier for communities to communicate with each other and share their experiences. Program teams and community groups are exploring ways to make media more interactive and participatory. These media have great potential to aid in scaling up demonstration or pilot efforts.

Scaling-up can also occur when communities apply what they have learned in one CM effort to other sectors. In addition, increased participation can change political systems, particularly by people who may not have participated previously.

### ***3. Scale-up happens naturally when the government and/or partnering organizations value the program.***

More often you will need to make a concerted effort to build awareness of the positive impact of a successful program to interest potential partners in the possibilities of going to scale with a new approach. The geographic isolation of some pilot programs, busy time schedules and divergent interests of potential partners, and preoccupation of program staff with program implementation often limit exposure of program successes and potential for scale.

Even when potential partners are interested in the program, they may not have the capacity, capabilities, and/or resources to implement it. Policy issues may also need to be addressed before a major effort can be undertaken.

**Even when potential partners are interested in the program, they may not have the capacity, capabilities, and/or resources to implement it. Policy issues may also need to be addressed before a major effort can be undertaken.**



## INDONESIA: Rushing to Scale Up

Experience from Indonesia in trying to scale up participatory rural appraisal (PRA) too quickly to national scale demonstrated how trying to rush the process can lead to costly mistakes. Here are some of the things that were not yet ready at the time that expansion was attempted:

- Strong top-down culture of development planning was not reconciled with participatory approach; it is difficult to tag on participatory approaches to existing national programs, as they often require other perspectives, values and methods.
- Too few sufficiently experienced in-country trainers resulted in poor-quality classroom-based training.
- The budget was unrealistic.
- The time constraints were unrealistic.
- There was poor collaboration between the government team and experienced NGOs.



## When to scale up

The timing of scaling-up efforts can affect the outcome; here are some important questions to consider when deciding what is the right time to substantially expand:

**Need:** Is the issue that your program is addressing a priority regionally or nationally? Do health indicators support this?

**Effectiveness:** Have you demonstrated that the proposed community mobilization approach improves health and a community's capacity to address its health and related needs?

**Efficiency:** Have you consolidated, defined and refined the approach so that it could be replicated or adapted by many others (individuals and organizations)?

**Feasibility:** Is there realistic potential for political and financial/resource support for the issue and the proposed community mobilization approach?

The answer to these questions should be “yes” if you want to effectively scale up the approach for maximum impact. Even when all the questions can be answered “yes”, it often takes more time and effort than anticipated to bring together all the necessary elements for a successful expansion. Later in this chapter, we will look at the steps that were taken by three community mobilization projects that have gone to national scale or beyond.

## BEFORE YOU SCALE UP...

### STEP 1: Have a vision to scale up from the beginning of the project.

From the very start of a new community mobilization program, your program team needs to envision how this approach could be expanded if it is successful. The team should think about and discuss the potential and possible steps for achieving scale. Identify point people and provide them with adequate time and resources to ensure that these steps are followed or that new steps are taken, if necessary. For example, point people may help to ensure that the project design takes into account the potential to scale up. As a result, teams may develop less resource-intensive approaches than they might have had the project vision been limited to a specific site.

Point people may want to explore the implications of initial partnership, keeping in mind the possibility of eventual expansion. They should develop a strategy to include potential partners in the program even if they are not formal implementing partners from the beginning. Asking for and being open to suggestions from other organizations helps to improve the program and involves more people in the development of the approach. If the program is successful, scaling-up will be easier as more people have participated in it and are familiar with its history. Similarly, if it is not successful, the lessons that can be learned will be helpful to everyone.

### STEP 2: Determine the effectiveness of the approach.

It is important to establish that the technical intervention, methodology, or approach that is being considered for scaling-up leads to desired results through



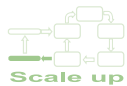
**Documentation...should begin at the start of a project and continue throughout its life. Many field workers don't have the time or don't like to write, and their experience gets lost because it has not been documented.**

carefully evaluated and documented research. The ever-growing demand for new and innovative approaches to involving communities in improving their health is, in some cases, leading to scaling up some approaches too quickly, without the necessary proof that the new approaches really do improve health or that they lead to other positive benefits and results. Scaling-up too quickly can waste limited, valuable resources that could be better used in other ways.

Documentation of a project's methods and experience is critical. It should begin at the start of a project and continue throughout its life. Many field workers don't have the time or don't like to write, and their experience gets lost because it has not been documented. To better document their experiences, field workers can try using audio cassettes or video, or having regular meetings where minutes are kept. Another reason field workers don't document their experience is because they may not think that it is anything special; it's simply what they do every day and they assume that others will not find what they have to say interesting or valuable. In this case, program managers can provide support by celebrating both little and big successes. Interested visitors can provide an outside perspective that helps field workers see how special their work really is.

To ensure that the approach is effective, both quantitative and qualitative evaluations should be done. Working with external evaluators is recommended because, although often more costly, they bring an outside perspective and can spot problems or positive aspects that those working on the program may not see. If evaluators are from another organization, the evaluation can be a learning experience for both organizations. The results of the evaluation will usually be received with more interest by other agencies, organizations, and donors when the evaluation has been done by a respected professional who is perceived to be relatively objective.

As mentioned previously in the evaluation chapter, participatory evaluation is also important because those who participate in the program know more directly what the experience has contributed to their personal lives and to the community in general. Often, they also know why certain problems arose and have good ideas about how to improve on existing methods. Community members who participate in evaluations and see the benefits of the program can be some of the best advocates for scaling up.



## STEP 3: Assess the potential to scale up.

Not all programs have the potential to scale up, or at least not in their existing form. It's important, then, to assess the possibilities for scaling-up and the potential barriers. Here are some questions to consider as part of your assessment.

- *Is there a real and perceived need for a large-scale program?*

Assessing the potential to expand a community mobilization approach is an ongoing process that, as mentioned above, needs to begin at the start of the program and should continue throughout the effort. The effort should address a real need (as demonstrated by health indicators), whether the need is openly acknowledged and expressed or is latent and awaiting validation and expression.

To achieve national scale requires human, financial, institutional, and other resources. When many people strongly perceive the same need, it is easier to access these resources. Generating resources to address latent needs often requires additional time to raise awareness at all levels about the need and to build consensus regarding resource allocation.

- *Who are the potential future implementers of the approach and how capable are they of reaching scale while maintaining quality?*

Some organizations view scaling-up as an opportunity to greatly expand their own coverage, impact, and resource base. From this perspective, assessing the potential to scale up involves assessing their capacity to grow to national scale. Then, as resources and opportunities permit, they increase their size and adapt their management systems to meet the requirements of their growth.

Others may scale up through partnership with other organizations. The original implementing team may change its role as a program expands, from an implementer to providing training and technical assistance to its partners.

**To achieve national scale requires human, financial, institutional, and other resources. When many people strongly perceive the same need, it is easier to access these resources.**



Another approach is to establish “living universities” (Marchione, 1999) in the communities that have participated in the program. These communities share their experience with other communities and serve as demonstration sites where experiential training can occur. For this approach to be sustainable, it still requires attention to institutional development and systems at the community level.

Some methodologies and approaches are picked up spontaneously by other organizations regardless of any deliberate plan by the originators of the approach. The caution here is to make sure that the approach really is effective and to maintain the quality of the approach so that the desired results will be achieved. While approaches can sometimes be adapted with little or no technical assistance or training, this is not usually the case.

The decision to adopt one or another of the above strategies is usually based on an organization’s philosophy and goals, its interest, capability, and capacity, as well as that of its potential partners and the practical realities of the setting in which it works. For example, if your organization’s goal is to build the capacity of local organizations and “work yourself out of a job”, then the first option of growing your own organizational presence as program implementers on a national scale is inconsistent with your organizational philosophy.

- *Is there political will on the part of policymakers and donors to support the effort on a large scale?*



Do donors and government agencies consider what is being addressed through the community mobilization approach a high priority issue? Have other strategies been tested and shown to be as effective as this approach in this setting? At what cost? What concerns donors and policymakers the most about the issue? How does the approach that you are proposing address these concerns? Are there other benefits that this approach delivers that others do not?





If the need is great in many communities but the issue is not yet on the agenda of policymakers and donors, you will need to dedicate more time to educating this audience about the realities on the ground and how communities are addressing their needs. Interested communities can and should participate in this process.

- *Are resources available to support the large-scale effort? What would be potential funding mechanisms?*

In some cases, resources are available and all that's needed is a strategy to determine how to best program these resources. Having an effective, well-defined approach and the tools to be able to expand the approach can be very attractive to donors looking for ways to achieve greater impact.

However, more often than not, you will need to consider multiple funding sources in order to reach a large-scale program. This requires patience, participation in many meetings, writing many proposals, and trying to meet the various needs of many actors while ensuring that you maintain the core values and key components of the approach. Count on at least a year to bring everything together and assume that some funding sources will come on line earlier than others. You need to be flexible and have contingency plans.

- *Would existing national and regional policies support or inhibit a large-scale effort? Which policies would need to be changed, if any? What is the likelihood that these could be changed?*

Pilot or demonstration programs may encounter policy and other obstacles to program implementation. Implementers and other stakeholders may work out ways to diminish or remove these through their on-the-ground relationships. When a program expands appreciably, these policies take on a different significance that may require advocacy to change them so that the program can be implemented in many sites.



## STEP 4: Consolidate, define, and refine.

The program design and/or interventions should be simplified as much as possible and written documents should be accessible in user-friendly language. Documenting and refining successful approaches is the first step. Systems need to be clear and easy to use; program training designs, for example, and monitoring, evaluation, and supervision systems need to be easily replicable. Staff must have adequate time and resources to develop and test systems and ensure that they retain the core values and elements of the program's success.

A mistake often made when a program expands is that only the activities and/or structures of the pilot program are replicated, not the process that led to them. For example, if pilot communities determined through their analysis and planning that they should form a health committee to coordinate community health activities, what is scaled up is that all participating communities should have health committees. What is lost is the more important process—that communities engaged in regular dialogue through which they themselves determined a particular course of action (in this case, forming a health committee).

## STEP 5: Build a consensus to scale up.

You will need to lay a foundation for scaling-up. Principally, this means building consensus for scaling-up among decision-makers, implementers, and leaders of those who participate in the program. You will have to introduce the intervention and make the case for its added value through meetings, presentations, and field visits with key individuals and groups.

Know your program and the elements that make it special. Staff members need to be skilled in making presentations to potential partners and donors and in discussing program elements, successes, and challenges. For community mobilization approaches to be effective, potential partners must be convinced of the capacity





## MALAWI: Scaling up the COPE Program

The Community Options for Protection and Empowerment program (COPE) is committed to mobilizing sustainable community-based and owned solutions to HIV/AIDS in Malawi. In the first phase of COPE (COPE I), the program undertook a broad range of interventions in nine villages near the town of Mangochi, Malawi. A joint review determined that although most of the interventions were producing positive results, the cost per beneficiary was too high to implement the staff-intensive approach at a larger scale. Another observation was that the continuation of COPE staff-initiated activities by community volunteers would be questionable once COPE staff moved on to work in another part of the District.

Taking the issue of scale (and sustainability) into account, COPE staff took a different approach in the Namwera area of the District during the remaining eight months of COPE I. Staff size was reduced from 20 to 9. The focus of the 9 remaining staff shifted from addressing problems at the community level to mobilizing and building the capacities of the community to address its own problems. COPE used its resources to breathe life into a structure of area- and village-level committees that had been devised by the National AIDS Control Program and UNICEF in 1994 but which did not function in most of the country. Staff management reconceptualized the role of COPE field staff, shifting away from direct implementation toward community mobilization. New field staff assembled and participated in a week-long training to prepare them for their revised roles.

The central responsibility of the community mobilizer—the new name that COPE field staff chose for their role at the end of the retraining—was to catalyze and train community members to undertake tasks that strengthened family and community capacity to care for orphans and other vulnerable community members. Each of the six COPE community mobilizers who were to work in the Namwera area were assigned several villages. In each village, the community mobilizer worked through existing structures and institutions and through newly organized village AIDS Committees. COPE I also supported the development of the community level Namwera AIDS Coordinating Committee (NACC). The NACC brought together talented and committed government health, community development, and education personnel; business people; and representatives of religious groups to help mobilize communities, particularly village AIDS Committees, against the impact of HIV/AIDS.

Phase II of COPE started at the district level—reviving, sensitizing, and mobilizing District AIDS Coordinating Committees to take the lead in mobilizing community and village AIDS Committees.

As COPE II seeks to make an impact over a much wider geographic area by working at a district level, efforts to lead and mobilize community and village AIDS Committees will become a particular challenge. It will be perhaps the most difficult test of whether this model can be a cost-effective and sustainable way of addressing the impacts of HIV/AIDS on a greater scale.

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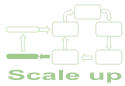
Mobilization at the district level is more difficult than at the area and village levels because the geographic scope of responsibility is much larger, members are further removed from problems, and ownership and sense of responsibility are more difficult to achieve in the face of extensive need. Also, distances to reach affected villages are large, and transportation is often problematic. Moreover, community-owned and managed responses mobilized through the district, community, and village AIDS Committee structure are not a package that can be replicated and expanded just by increasing the resources dedicated to it. It is an empowering process that must develop from a sense of responsibility for addressing the problem and a sense of ownership of the response.

The challenges to come to scale while retaining quality and impact are many. The field office's strategy was to slow down expansion of COPE II while the essential processes of COPE's program success were refined and documented. Steps taken include:

- Documenting the community mobilization process. COPE worked with a full-time Peace Corp volunteer who helped key staff in the field develop a *Manual on COPE Implementation*. The *Manual* will provide guidance as to the key steps, lessons learned and overall process utilized by COPE at the community, district and national levels.
- Refining and packaging curriculum designs. COPE's *Training for Transformation* for District Level mobilization as well as Technical Subcommittee training design for *Home-based care; Orphans; Youth; and High-Risk Technical Subcommittees* are being developed with assistance from a consultant with curriculum design expertise and input from staff who designed the original training. These training manuals will complement the *Manual on COPE Implementation*.
- Defining and simplifying monitoring and evaluation systems. Monitoring and evaluation systems need to be better defined and simplified so that they can more easily track program impact at both the community and district levels and contribute to regional and/or national level monitoring of future impact.
- Operations research for proving effectiveness. Outside technical agencies skilled in operations research are assisting COPE to explore essential questions on program impact, including sustainability and cost-effectiveness.
- Program critique/sharing lessons with external partners. COPE staff has organized a lessons learned/best practices workshop amongst programs in the southern Africa region working on similar prevention-to-care community outreach models.

When these steps have been completed, the COPE program will not only be better positioned to reach greater scale, but will have a greater chance to be adopted and adapted by partnering organizations.

*Save the Children Federation (US), Malawi field office*



of communities to improve their health. Those who have had less direct contact with the power of community organizing, particularly in working with people who have less formal education and control of fewer resources, will need to determine whether they really believe in the power of the approach and assess their organizational commitment and capabilities before they decide to join an expanded effort. You may want to refer back to Chapter 1/step 2: Criteria for selecting team members, and the box called “Are you ready to commit to community mobilization?”

**For community mobilization approaches to be effective, potential partners must be convinced of the capacity of communities to improve their health.**

## STEP 6: Advocate for supportive policies.

Before expanding a community mobilization program, you will need to look at the existing policies in the country and determine whether or not they present any barriers to effective large-scale program implementation. Are the relevant policies supportive and neutral, or will they inhibit the program’s effectiveness and reach? If existing policies seriously restrict the ability of the program to function, you should consider whether these policies could or should be changed. In most cases, you will need to include an advocacy component in your scaling-up effort.

Many resources are available on how to advocate for policy changes, some of which are listed under Resources at the end of this chapter.

## AS YOU SCALE UP...

Once all (or most) of the pieces are in place to begin to scale up, certain steps should be taken to implement the new approach. You will need ample time to ensure that all of these steps (and some others that you may determine are necessary) are carefully taken.

## STEP 7: Define the roles, relationships, and responsibilities of implementing partners.

All of the partners involved in scaling-up will need to determine who will be responsible for program training, supervision, monitoring and evaluation, resource allocation, funding procurement, management, and information systems and other functions.

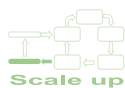
They should develop a clear organizational structure with well-defined roles and responsibilities of all implementing organizations and individuals, to avoid misunderstanding and ensure that expectations are realistic and achievable. It will also help to maximize resources by avoiding duplication of effort.

These partners will also need to give some thought as to what the role will be of the original organization that piloted the approach. This organization could:

- Continue to implement the program as one of many organizations to contribute to overall coverage.
- Provide technical assistance and training.
- Remove itself from implementation and act in an advisory or monitoring role.
- Have no role at all in scaling-up.

Meanwhile, the implementing partners will have to decide how they are going to coordinate their activities. Once again, they could decide to organize themselves in one of the following ways:

- Determine that each will implement the whole approach in its own geographic area, thereby covering a larger area.
- Organize themselves based on functions (e.g., training, monitoring and evaluation, fieldwork in communities, policy).
- Opt to strengthen local community and/or organizational capacity to carry out the work.



- Choose a combination of the above.
- Develop their own concept of coordination through networks, coalitions, “franchises,” or other possible scenarios.

Whatever is decided, all of the organizations involved should clearly spell out their decisions in a document such as a Memorandum of Understanding or Agreement so that partners understand their roles and relationship to others and how they fit into the larger effort.

### STEP 8: Secure funding and other resources.

The amount of funding needed for large-scale programs is often not available through a single donor. The partners will probably need to negotiate contracts, budgets, and work plans both with partners and donors. They should be sure to include funding for refining and packaging training modules, program process and implementation, and educational materials, so they meet the needs of various cultures and geographical areas. Funds are also usually required for technical assistance. In short, they should be prepared to solicit many donors and negotiate many hours in order to put all the pieces into place. Partners may decide that it is more effective to work together on joint proposals or may opt to seek support individually. Discussing the pros and cons of various resource-generation strategies among themselves can prevent partners from working at cross purposes and competing against one another for precious program resources.

### STEP 9: Develop the partners’ capacity to implement the program.

Implementing partners that choose to adopt a new approach may not be able to effectively implement it without orientation, training, and technical assistance. The original CM program team, therefore, will need to prepare training and technical assistance teams and materials for use at the regional or other levels depending on organizational structure. Reading a manual or talking with field workers from

**It is essential that partners support participatory approaches, not only in the field but within their own organizations.**

other organizations who have program experience will not adequately prepare the partners to go out and do the work, especially if the participatory approach is not part of the partners' culture. It is essential that partners support participatory approaches, not only in the field but within their own organizations.

One way to help new partners experience the participatory approach is through modeling. Centers for learning and living universities are examples of modeling which have proved immensely useful for replicating programs. The Vietnam Case Study, presented later in this chapter, illustrates how living universities were used to introduce interested individuals and groups to the positive deviance approach to nutritional rehabilitation.

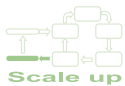
Partners can also model the types of attitudes, behaviors, relationships, systems, and processes they are attempting to implement with communities in their own organizations and in the ways that partners relate to one another. In particular, partners can ensure that their structure, decision-making, planning, and monitoring and evaluation processes are consistent with the participatory community mobilization approach. When your systems and experience are aligned with your vision, it is easier to stay on course.

### **Training for scaling-up**

Partners must answer several questions when developing a training system and structure for a regional or national level program.

- *Who will provide the training at each level (national, regional, municipal/district, community)?*

The answer to this question will depend on many factors, including: who the implementing partners are and where their strengths lie; whether the intent is to sustain the existence of a training team over the medium to long-term; who has direct experience implementing the methodology; whether there are policies that dictate certain qualifications for certain levels of worker (if there are, these may be





a barrier to having the most experienced field workers involved and you may want to explore the possibility of exceptions or changes in policy); and what resources are available (time, funding, space, human talent).

- *What methods will be used (e.g., workshops, in-the-field observation and practice, coaching)?*

It is helpful to develop a complete package of training materials to support a large-scale effort, including manuals, training plans and curricula, and materials developed by the original project (adapted for the regional level if necessary).

- *How will we assess and monitor the skills and needs of trainees over the life of the program?*

It is not sufficient to provide only initial training. You cannot assume that trainees will completely understand and adopt new methods and need no further assistance. Staff training and development are essential to community mobilization, because community mobilization approaches are intended to build community capacity, and results depend to a large extent on the ability of field workers to transfer multiple skills and technologies to community members and organizations.

Establishing systems that enable implementers to assess on a regular basis how they are doing and whether they need refresher training or additional support helps to maintain quality. This process does not have to be a difficult or complex process. It may consist of developing a self-assessment tool that is administered once a quarter or every six months, coupled with field visits by supervisors and/or trainers. Monthly or quarterly meetings at which trainers and trainees can share their successes and difficulties and discuss common problems can be helpful if they are focused on results and how to improve the quality of the work.



## STEP 10: Establish and maintain a monitoring and evaluation system.

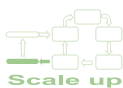
Program implementers need to meet regularly on the local, regional, and national level to monitor progress, identify problems, develop innovative solutions, strengthen skills, and build the team.

It is important to establish participatory systems that provide for regular monitoring of both process and outcome indicators. For example, monthly meetings at the local level, quarterly evaluation and planning sessions at the regional and national levels, and periodic checks on specific strategies will help to detect problems as they arise and allow for timely adjustments. Simple instruments and tools to help program teams at each level to monitor their progress should be developed with the team members and used to help synthesize information and detect trends over time.

## STEP 11: Support institutional development for scale.

For community action to be sustained over the long term on a larger scale, it needs to depend not on individuals but on organizations and/or networks dedicated to the issue—in this case, health.

It is not realistic to assume that a community mobilization effort on one specific theme will be sustained forever. However, in many cases effective community mobilization approaches stimulate individuals and groups to organize around a theme and develop the necessary skills to continue to improve their health and well-being. Associations of community volunteer health workers, such as the one presented in the Philippines Case Study later in this chapter, are a good example of how community volunteer health workers organized to gain support. Advocacy groups and coalitions can build support for ongoing assistance to communities as they learn to better identify and address their health needs. Initially,



these associations and groups may need assistance to help them establish goals and objectives, develop management and financial systems and procedures, particularly when members have not participated in this type of group before. As these groups gain the skills and experience they need, they become more adept at planning their strategies, accessing resources, and linking with other organizations.

Many resources are available on institutional development to assist partners in this phase of a program. Some of these are presented in the Resource list at the end of this field guide.

This chapter concludes with a summary of lessons learned, followed by three case studies of scaling-up (in Vietnam, Bolivia, and the Philippines).

### Summary of lessons learned

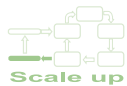
- To scale up successfully, management and coordination systems must be carefully designed so that information, human, and financial resources can be used most effectively to reach greater numbers of families in need.
- Interinstitutional coordination is key to the success of the scaling-up effort. The coordination with the Ministry of Health is not just at the executive level, but negotiation and action takes place at the regional, district, sector, and area levels as well.
- Training and technical assistance in program methods must be provided and a variety of media used to spread the methodology, tools, and lessons learned on a regional, national, or international level. Establish a small team that will provide technical assistance and training to other organizations or communities that choose to implement the program.
- The technical personnel in charge of coordinating with partner agencies



**Interinstitutional coordination is key to the success of the scaling-up effort.**

should possess the following characteristics: high level of skill in nonformal education methodologies, ability to speak the regional language, exceptional interpersonal skills so that they are capable of obtaining the acceptance of the communities, and commitment to stay with the project for at least two years.

- It is important to work with communities that participated in the successful initial pilot sites to establish them as “living universities” where others who want to learn the methodology can go to get hands-on training and experience in the field.
- Implementing partners should disseminate knowledge of successful methods and tools through regional or international workshops or conferences; introduce training tools at workshops where participants can practice using them; and establish support groups of trainees so that they can learn from each other’s experiences and provide assistance when implementation does not go exactly as planned.
- Organizations will learn what works and does not work through their own experience in the field. The benefit of having on-the-ground technical assistance from organizations that have successfully implemented the methodology is that these lessons have often already been learned and could have been shared with new partners.
- Mechanisms should be developed to aid communities that are interested in replicating or adapting the methodology or using the tools. Contact information at the end of the television or radio programs or print stories can lead the audience to a website or contact address for more information. Media centers and clearinghouse experience will prove invaluable in this effort.
- The parameters of any partnerships should be defined at the beginning. If possible, make the terms as clear to both parties as possible by forging a



written Memorandum of Agreement or Understanding

- Partners need to work from the same paradigm. Both organizations should operate on the principle that workable and sustainable community health activities should be designed within the context of a community-managed health system and not just from the point of view of the health providers.
- Partners must have mutual trust and be open and honest with each other to survive. They should recognize mutually beneficial strengths and help each other overcome weaknesses, and they should seize every opportunity to strengthen the partnership through other activities or projects even if they are outside the bounds of the partnership.
- Interorganizational learning involves not only sharing each other's special skills but also the pool of technical resources that may be made available to each partner.

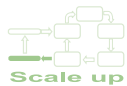
The following three case studies from Vietnam, Bolivia, and the Philippines present different approaches to scaling up program impact. In Vietnam, the program team

# Case Studies

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developed a living university where other interested organizations and community groups could go to learn about and see in action the positive deviance approach to nutrition rehabilitation. In Bolivia, a network of NGOs, the MOH, and various donors established a partnership that led to a national program to adapt the *Warmi* methodology that the partners supported through regional training, technical assistance, monitoring, and coordination. In the Philippines, a Department of Health/NGO partnership created policy and operational support for community volunteer health workers throughout the country, thereby validating the role of these community volunteers, strengthening their technical capacity and, ultimately, better sustaining their valuable contributions to their communities.

Even though the approaches are different, you will see that many of the steps these three programs took to scale up impact were similar to the steps presented earlier in this chapter.



## CASE STUDY 1

### Vietnam—Scaling-Up a Poverty Alleviation and Nutrition Program

**Jerry and Monique Sternin**

#### Going to scale with quality

In March 1993, Save the Children was authorized to expand the successful pilot Poverty Alleviation and Nutrition Program (PANP) to an additional ten communes with a population of 60,000 people in Thanh Hoa province. The Vietnamese National Institute of Nutrition (NIN) seconded six staff members to Save the Children to assume responsibility for scaling-up the program while maintaining its positive outcomes.

The primary objective for the expansion of the PANP to fourteen communes was to demonstrate that the dramatic results achieved in phase one could be achieved on a larger scale utilizing national staff. Going to scale while maintaining the quality of the original model presented a set of critical challenges. Among these was the transfer of responsibility for program implementation, training, and evaluation at the field level from expatriate staff to Vietnamese staff. Extended visits to the original four villages provided the new NIN staff with direct encounters with the model in addition to the conceptual framework presented through numerous workshops. NIN staff were also asked to evaluate the ongoing project, a process that afforded them broad access and contact with village leaders, program beneficiaries, and villagers at large.

Using NIN staff as program trainers provided, not unexpectedly, both advantages and challenges. As trained professionals, their knowledge of nutrition improved the technical component of the Nutrition Education/Rehabilitation Program (NERP) protocol. As Vietnamese, their understanding of the socio-political context



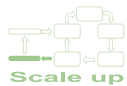
of the village led to structural innovations in program management, beyond the reach of the expatriate staff responsible for the original model.

The other side of the “expertise” coin, however, has been the skepticism about the value of villagers’ knowledge, experience, and wisdom: the “doctor knows best” syndrome. Inherent in the success of the original model was the reliance on villagers to identify solutions to their own problems. It was the conscious absence of a preconceived plan of action that led, for instance, to the development of the NERP, based on untapped but readily available food resources found in the villages. Modification of the NERP diet and introduction of poultry loans were also the direct results of villagers’ ownership of problems and responsibility for finding their solutions. Without a genuine belief in the villagers’ wisdom, the model simply could not have succeeded. Hence, the success of program expansion was contingent to a large measure on the ability to inculcate that conviction in the trainers.

The conversion of NIN staff from technical experts to process-sensitive trainers was a significant challenge. It was equally important for building consensus around program process and content in order to begin to scale up. What emerged from the experience, however, was a clearer understanding of the requisite skills for program trainers, which tended to be heavily weighted towards process rather than technical expertise. The effectiveness of the technical content of the NERP, the growth monitoring program (GMP), and the Health Pregnancy/New Mother Program had been demonstrated and documented. Still required to scale up were the skills to transfer that knowledge and to add to it by effectively tapping the experience and knowledge of villagers in new communes.

### Expansion of the program

Since the primary challenge of the expansion phase was the transfer of program implementation and management to NIN staff, a three-step geographic expansion maximized opportunities to build upon lessons learned and problems perceived. The first expansion began in March 1993 in three new villages, followed by another three in July, and a final expansion to four villages in a new district, Tinh Gia, in November 1993.





In all, ten new villages, with a total population of 63,774, were selected by the districts and Save the Children staff based on the results of a nutritional baseline carried out by the Vietnamese NIN.

After providing the new health volunteers with training in GMP, the NIN staff and Health Volunteers undertook the positive deviance study to determine the appropriate content for each village for its Nutrition Education and Rehabilitation Program protocol. Lessons learned from the first GMP in the first three villages demonstrated that the training of the health volunteers was inadequate.

Consequently, NIN staff held additional workshops to upgrade growth card plotting skills of the health volunteers, and of equal importance, increased the time allowed for GMP training in the subsequent two groups of new villages. The trainers allotted additional time for training where necessary and improved training materials based on experiences gained in each stage of expansion. These intense training demands for time and personnel and the surveillance were necessary only during the program development stage. Improvements over time in training techniques and materials enabled health volunteers, for example, to greatly improve the accuracy of GMP plotting.

The expertise gained over the first two and a half years by villagers in the original program communes provided an excellent resource for the people in the villages and added to expanding the program. The utilization of “old villages” as consultants not only contributed to a smoother program implementation in the expanded villages, but reinforced the knowledge and sense of empowerment of the contributing consultants and their villages. Health volunteers, People’s Committee, and Women’s Union leaders and members took an active part in training new villagers in program objectives, implementation, and protocol.

The creation by the NIN staff and villagers of a NERP management committee in the expanded program villages proved to be an important innovation and an effective vehicle for increased program participation and ownership at the highest level. In the original pilot villages, an individual such as the Women’s Union

chairperson or the head of the clinic managed NERP. The head of the People's Committee, the Party chairman, the head of the Women's Union, and one commune health center staff comprised the management committee in the expansion villages. The committee members viewed their role as "ensuring the overall management, implementation, and monitoring of the program." Committee members attended NERP sessions and checked on hygiene, menus, and eligibility of attending children. Their assistance not only contributed to the overall conduct of the NERP and other programs, but also greatly enhanced the commune's official commitment to children's health and nutrition.

### **New district, new opportunities**

The expansion of the program to a new district, Tinh Gia, in November of 1993 provided an opportunity to utilize the commune Management Steering Committee concept at the District level for the first time. A meeting held at the Tinh Gia People's Committee focused on expectations, roles, and responsibilities. Unlike the program in the original villages, where district level Women's Union, People's Committee, and Cadre had a somewhat peripheral role, those entities were asked to assume a principal management role for program implementation and monitoring. The management role was developed to help sustain the program and for scaling-up as well.

As managers of the program, the district assumed responsibility for the overall implementation and quality of the program. Women's Union leaders visited NERPs and Pregnancy Day programs. People's Committee members checked on the commune's financial management of loan programs and development endowments. District health and family planning cadres participated in training village health staff for pregnancy monitoring. Growth Monitoring and NERP results were passed by the commune to the district rather than to Save the Children as in the



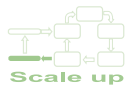
original communes. Hence, after program phase-over at the commune level, the district remained responsible for resolving problems. By managing the overall program, the District Steering Committee developed a comprehensive understanding of the specific programs and their impact. This enabled them to replicate individual components on their own in other communes throughout the district. With only minimal external financial assistance, specific components of the program could be implemented in nonprogram villages by district level cadres who participated in training and management of these protocols. This strategy facilitated a redefinition and enhancement of roles, district leaders as program catalysts rather than the more passive role of district leaders as program partners.

### Summary of lessons learned

To scale up successfully:

- Manage and coordinate systems carefully so that information, human, and financial resources can be used most effectively to reach greater numbers of families in need.
- Provide training and technical assistance in program methods and use media in interactive, participatory ways to expand successful pilot projects' reach to a regional or national level.
- Work with communities that participated in the successful initial pilot sites to establish them as living universities where others who want to learn the methodology can go to get hands-on training and experience in the field. The living university concept provides a demonstrably successful mechanism for program expansion and replication which enabled Save the Children/Viet Nam's nutrition program to expand from 4 villages (population of 40,000) to 160 villages with a population of over 1.5 million, while maintaining the quality and impact of the program.

- Establish a small team that will provide technical assistance and training to other organizations or communities that choose to implement the program. When organizations have been through several cycles with assistance, they will not require much additional help. Similarly, communities that have internalized the process will be capable of applying the cycle to new problems that they or others identify.
- Use a variety of media to spread the methodology, tools, and lessons learned outside of the country. Television, video, and radio are particularly well suited to tell communities' stories in ways that others in neighboring or far-off countries can learn from them.
- Develop mechanisms to aid communities that are interested in replicating or adapting the methodology or using the tools. Contact information at the end of the television or radio programs or print stories can lead the audience to a web site or contact address for more information. Media centers and clearinghouse experience will prove invaluable in this effort. Another way to spread the use of successful methods and tools is through regional or international workshops or conferences. Training tools can be introduced at workshops where participants can practice using them. Support groups of trainees can be established so that they can learn from each other's experiences and provide assistance when implementation does not go exactly as planned.
- Seek to include case studies in public health courses from which students can learn and improve upon in the future as community and family needs change. Distance education will further increase access to this information and can provide tailored technical assistance directly to program implementers in the field.



## CASE STUDY 2

### Bolivia—Scaling-Up *Warmi*: Mobilizing for Reproductive Health

Fernando Gonzales, Elizabeth Arteaga, and Lisa Howard-Grabman



#### Introduction

Bolivia's maternal, perinatal, and neonatal mortality rates are higher than in any other country in the Western Hemisphere except Haiti. Bolivia's National Institute of Statistics (INE/ENDSA) estimates a national maternal mortality ratio of 390 per 100,000 live births (1994) and an infant mortality rate of 64.6 per 1,000 live births (1998). Mortality rates in some rural areas of Bolivia have been estimated to be two to three times higher than the national rates.

The *Warmi Project* was developed by Save the Children/Bolivia under the USAID-funded MotherCare project to demonstrate what could be done to reduce maternal and perinatal mortality at the community level in isolated rural areas with limited access to health services. The pilot project was carried out from 1990 to 1993 in 50 communities in Inquisivi Province. A gender-sensitive participatory methodology, now known as the Community Action Cycle, was developed to work with women's groups and other community members to improve maternal and perinatal health in their communities. The Community Action Cycle then consisted of four phases: Autodiagnosis (problem identification and prioritization), Planning Together, Implementation, and Participatory Evaluation. The project achieved many noteworthy results, including a reduction in perinatal mortality of nearly 50 percent and improved practices related to prenatal care, breastfeeding, immunization, and other behaviors. In addition, women increased their participation in the community planning and decision-making processes.

## Results

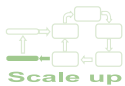
Efforts began in 1994 to replicate *Warmi* at the national level involving two bilateral agencies (USAID-supported Child and Community Health Project and the Health Strengthening Project supported by the Inter-American Development Bank and the GTZ), an NGO umbrella group (PROCOSI), and government health services in selected districts. Nationwide, 445 *Warmi* women's groups were organized and SC/B trained 180 technicians from the Ministry of Health (MOH) and 70 technicians from PROCOSI in the four phases of *Warmi* Community Action Cycle methodology. By 1998, after three years of implementation on a national scale, the *Warmi* methodology had reached 513 communities in 29 Health Districts in eight of the nine departments in Bolivia.

In all cases, the *Warmi* methodology helped to increase women's participation in the community. During this process, women's group members not only developed their communication skills, but also learned how to plan interventions and negotiate with other community organizations to improve health conditions.

The goal of the National *Warmi* Project was not only to conclude the community action cycle in all of the communities that initiated it, but to develop the capacity of each health district to implement the *Warmi* Project methodology on its own. The National *Warmi* Project aimed to create the necessary structure, technical capacity, and resources in each participating institution to achieve this goal, and it has been largely successful. While USAID funding for SC/B's technical assistance and training component of the project has ended, the methodology continues nationwide through the participating partner agencies.

## Scaling-up strategies

Save the Children/Bolivia used many strategies to scale up the *Warmi* Project to improve maternal and neonatal health nationwide, especially in rural areas of Bolivia.



These strategies were:

- Develop, implement, and document a successful demonstration project.
- Disseminate project methods and results.
- Advocate to build consensus and influence policy.
- Mobilize resources.
- Define the organizational structure and philosophy of the national project.
- Establish agreements with partners (MOH and NGOs).
- Provide training and technical assistance.
- Coordinate activities with partner agencies.
- Develop and use monitoring and evaluation systems.

This section briefly describes each of the above strategies.

### **Develop, implement, and document a successful demonstration project**

The *Warmi* Project was designed to serve as a pilot project that, if successful, could be expanded to many communities in similar settings. When developing the initial project proposal, program planners looked for possible avenues for future replication of the project and identified members of PROCOSI, a network of PVOs and NGOs working in child survival in Bolivia, and the MOH as potential partners.

Selected PROCOSI members and MOH staff were invited to participate in the demonstration project's mid-term and final evaluations. All PROCOSI members were invited to attend presentations of the results of the mid-term and final evaluations. SC/Bolivia invited suggestions and comments from participants in these events. The PROCOSI members' active participation helped to establish a base upon which to have a more involved discussion of the project and its potential replication or adaptation by PROCOSI members in the future.

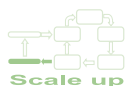
## Disseminate project methods and results

The *Warmi* Project disseminated its methods/results via four key products: a manual entitled, *The Warmi Project: A Participatory Approach to Improve Maternal and Neonatal Health*; two papers written for the MotherCare Working Papers Series detailing the project's experience with the Community Action Cycle; and a 17-minute video summarizing the project methodology and results.

## Advocate to build consensus and influence policy

Following the initial dissemination phase, SC/B and USAID staff made visits to each PROCOSI member organization individually to speak with directors and health program advisors to determine whether they were interested in using the *Warmi* Project methodology in their project areas. Some of these visits were followed by additional presentations for groups of program staff to brief them on the methodology and results. When there was sufficient interest in expanding the *Warmi* methodology and other reproductive health activities, PROCOSI members met again as a group to discuss project goals and objectives and develop a logical framework for the project.

At the time of scale-up, a new national administration dedicated to decentralization had begun to explore ways to increase popular participation at the community and municipal levels, a goal consistent with *Warmi* Project methodology and philosophy. SC/B was invited to participate on the national commission to develop the maternal and reproductive health component of the national health plan to represent a community-based perspective. The *Warmi* Project methodology was then included in the national health plan (*Plan Vida*) as an approach to working with communities to improve maternal and neonatal health. Several policies were introduced into the plan as a result of *Warmi's* field experience, including recognition of community-based midwives as a part of the district health referral network. The plan validated the need to make family planning services available in rural areas and created the opportunity for many other improvements.





## Define the organizational structure of the national project

When *Warmi* went to scale, a national project team was formed, consisting of five Save the Children/Bolivia field office staff, five Ministry of Health staff, and one representative from each participating NGO or bilateral agency.

National level :	SC Project Coordinator and MOH National Coordinator Secretariat of PROCOSI
Regional level:	Regional SC Trainers (1 trainer per 2 regions/departments) MOH Regional Coordinators NGO Regional Coordinators Bilateral Regional Coordinators (CCH and PSF)
District level:	District Director (MOH) NGO implementing personnel MOH implementing personnel (primarily auxiliary nurses)
Community:	Women's Group President and other officers Local leaders (Mayors, other municipal government officials, and others), community members

The National *Warmi* Project coordinators (from SC/B and MOH) oversaw all project implementation and played an important role in bringing project partners together to plan, discuss strategies, monitor overall project progress, and coordinate data collection. They also provided technical assistance to the regional teams as needed. SC/B staff worked with MOH counterparts at the regional level which led to good coordination of activities and reinforced teamwork.

## Mobilize resources

Mobilizing resources for the National *Warmi* Project was a challenging and complex task that required months of consensus building, negotiation, proposal

development and review, and patience. The USAID/Bolivia Mission provided funding to PROCOSI (approximately \$4 million over a three-year period) for its members to carry out reproductive health activities including *Warmi* Project replication/adaptation. The USAID-funded MotherCare Project provided approximately \$360,000 to SC/B over a three-year period to provide coordination, materials development, technical assistance, and training for all implementing partners. The USAID-funded Child and Community Health Project (CCH) and the Inter-American Development Bank PSF Project provided its own funding to replicate the *Warmi* methodology in the ten districts in which they worked.

### **Provide training and technical assistance**

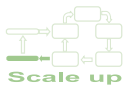
SC staff held participatory workshops in each region throughout the country to train NGO and district MOH facilitators in each phase of the Community Action Cycle methodology. The SC/B staff then visited field sites to assist partners with their own workshops and field work with communities. SC/B's supportive role and openness to being flexible in the adaptation of the methodology to local realities helped to increase their partners' ownership of the methodology.

### **Establish agreements and coordinate with partners (MOH and NGOs)**

SC/Bolivia developed written agreements with each participating organization and with the Ministry of Health at the national, regional, and district levels. The agreements clearly established the roles, responsibilities, and contributions of each party as well as the desired project results and products.

### **Develop and use monitoring and evaluation systems**

Throughout the project, SC/B coordinated monitoring and evaluation in each of the participating health districts through the following activities:



- Regular site visits to monitor progress and provide technical assistance
- Monthly evaluation and planning meetings in each district
- National evaluation workshop (1 per year)
- Mid-term evaluation
- Mid-term regional evaluations (7 per year, 1 per region)
- Final evaluation

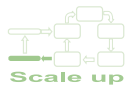
At the first National Evaluation Workshop held in March 1996, the participants defined and decided upon impact indicators which are now included in the Bolivian National Information System (SNIS).

### Summary of lessons learned

- Multilateral efforts require more time to implement. Coordinating the activities of various organizations working together also takes time.
- Communities lose interest in the process if long periods of time pass without follow-up by the trainers, particularly during the initial community action cycles. The implementing organization loses credibility in the eyes of the community when follow-up is not punctual.
- Before beginning to implement the *Warmi* methodology, it is important to understand the community, paying particular attention to socio-cultural factors. When working in communities where women normally do not participate in decision-making, it is important to solicit the approval of male leaders and husbands (to prevent resistance) and to encourage men's participation.
- The *Warmi* methodology creates demand for information and immediate services. The institutions implementing the *Warmi* Project and health providers serving *Warmi* Project areas should plan for this increase in demand. Communities generally request information on such themes as the importance of pre- and post-natal exams, sexually transmitted diseases and infections, and others. To respond to this demand, materials need to be obtained and/or

developed and health personnel need to be well trained in all aspects of reproductive health services. Service providers should also ensure that they have sufficient commodities and supplies on hand to meet the increased demand for family planning and other reproductive health services.

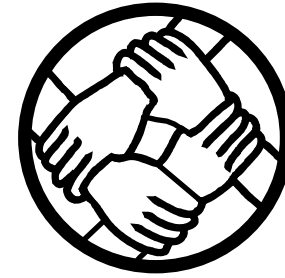
- Several important achievements support the likelihood that the project and the *Warmi* methodology will be sustained including:
  - ◆ Community leaders have been trained in and use the methodology.
  - ◆ The project is articulated in the national health plan.
  - ◆ NGOs and partners use their own resources to pay for technical assistance and to implement the methodology in new project sites.
  
- Interinstitutional coordination is key to the success of the scaling-up effort. The coordination with the Ministry of Health was not just at the executive level, but at the regional, district, sector, and area levels as well.
  
- The technical personnel in charge of coordinating the *Warmi* Project for partner agencies should possess the following characteristics: high level of skill in non-formal education methodologies, ability to speak the regional language, exceptional interpersonal skills so that they are capable of obtaining the acceptance of the communities, and commitment to stay with the project for at least two years.
  
- Community participants must see results quickly. The participatory processes take time and women's time is valuable. The original *Warmi* methodology was time intensive, particularly when women's groups did not exist prior to the project and participants had not had experience with group processes such as priority setting and planning. The *Warmi* team responded to this situation by revising their methodology and reducing the total time required to implement the entire process from eight months to six.



## CASE STUDY 3

### Philippines—Scaling-Up the Community Volunteer Health Workers Program

**Naida G. Pasion**



#### Introduction

In the Philippines, 250,000 front-line health workers called Community Volunteer Health Workers (CVHWs) reach about 60 percent of the population. The role and the stature of these workers in the Philippine public health sector have evolved greatly since the government signed the Alma Ata Declaration in 1979. At first, the CVHWs were considered as adjuncts to the midwives. Thus, they were asked to do menial or routine jobs in the health centers, such as taking vital signs, weighing patients, locating individual consultation records, and more often than not, providing janitorial services. Over time, the vital role of the CVHWs in the health system was increasingly recognized. Rather than being treated as a “side-kick” of the midwife, the CVHWs assumed more meaningful responsibilities in both the community and at the health centers and were active in practically every major public health event in their communities.

Various studies have documented the importance of CVHWs and the effects of their committed service to the communities. In Bohol province, for example, they were instrumental in helping to lower ARI-specific mortality, and they have also consistently been credited for their important contribution to the achievement of high EPI coverage rates nationwide.

## An NGO and government partnership to support CVHWs

In recognition of the CVHWs' important role in child health, Save the Children (SC) actively pursued a partnership with the Department of Health to further improve CVHW performance and support systems. To formalize the partnership, both parties signed a Memorandum of Agreement in 1995. The document officially defined the respective roles and commitments of both partners, including the establishment of a CVHW Unit at the Department of Health to be responsible for setting the long-range vision for the CVHWs, so that at some future date they could become an independent entity and a formally recognized government partner in the delivery of health care.

The partnership was marked by major achievements including the following milestones:

- In 1995, the Philippine Government enacted the Barangay Health Workers Act of 1995, granting benefits and incentives to accredited *barangay* (village) health workers. The act applies to all *barangay* health workers who have undergone training provided by any accredited government or nongovernment organization and who voluntarily render primary health care services in the community after having been accredited to function as such by the local health board.
- In 1996, the Implementing Rules and Regulations of the Barangay Health Workers Act was approved, which led to greater involvement of other national government agencies.
- In 1997, the Department of Health provided funds to Save the Children to pilot-test an advocacy campaign for local government support to CVHWs among selected local government units in two provinces. The experience showed that with adequate information and motivation, local government units (LGU) were ready and willing to provide financial and logistical support, as well as formal



LGU recognition of the role of CVHWs . As an output of the advocacy sessions, municipal government units increased the transportation allowance of their CVHWs and provided an annual budget for their regular upgrade trainings.

- In 1998, the Department of Health decided to embark on a comprehensive capacity-building project for the CVHWs entitled the Barangay Health Workers Continuing Learning for Sustained Service, otherwise known as the BHW CLASS Project. The new training program focused on family health, with an emphasis on the needs of children and women—the most vulnerable members of the family.

The SC and DOH partnership had a formal mandate to develop a nationwide training system for CVHWs which was learner-oriented and which would incorporate the best features of trainings that have been conducted by both the government and the NGOs.

This assignment included training of 150 national core of trainers from the DOH and local NGOs who would then be accredited to train CVHWs. Likewise, SC was commissioned to develop a monitoring system which would measure the performance of the CVHWs as a result of the training. The system, among other things, provided a national picture of the performance of the CVHWs in relation to key child survival activities such as immunization, oral rehydration, and micronutrient supplementation.

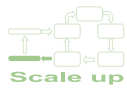
The Barangay Health Workers Act became a legislative landmark for CVHWs and a major step by the national government to ensure the sustainability of the CVHWs and to formalize their role in the mainstream health system. The CVHWs have organized themselves at the barangay level and in most areas are federated at the municipal and provincial levels. There are now regional CVHW federations, area federations for each of the three major island groups of the country, and a national CVHW Confederation. This intricate pattern of associations is slowly shaping the CVHWs as an emerging political force.

In the NGO community, SC's partnership with the DOH constitutes a model of how an NGO can work with government at the national level. In the same manner, some NGOs working at the subnational level have been encouraged by this experience to further their partnership with local government units.

### Summary of lessons learned

The road to the DOH-SC partnership has been long and winding, yet it has survived multiple changes of administration. Both negative and positive experiences within the partnership helped to shape simple lessons in partnering between a nongovernment and a government organization seeking to improve its work in child survival. The following are the most significant insights in the partnering experience:

- Define the parameters of the partnership at the beginning. If possible, make the terms as clear to both parties as possible by forging a written Memorandum of Agreement or Understanding. For SC and DOH, it was clear from the outset that the DOH sought the partnership because of SC's focus on children, particularly those under age five where illness and death are concentrated. The Memorandum of Agreement states this common concern for the welfare of the children and identifies the CVHWs as the means by which those most in need can be reached.
- Work from the same paradigm. Both organizations are operating on the principle that workable and sustainable child survival activities should be designed within the context of a community-managed health system, and not just from the point of view of the health providers. The DOH slogan, "Health in the Hands of the People," defined the common vision which transcended institutional differences.
- Be sure the partnership is between two institutions, not between individuals. We have observed that many partnerships in the Philippines were not sus-





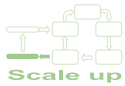
tained because the purposes and terms of the partnerships did not permeate the multiple levels of the organizations that need to be committed to the agreement.

- Observe mutual trust and transparency. The partnership has survived and continues to thrive because of a simple adage: what you see is what you get. There were no instances where one organization manipulated the other to be in an advantageous position. It helped that the core staff who were in the partnership remained through the years. Staff were added, but few were replaced from either side.
- Recognize mutually beneficial strengths and help each other overcome weaknesses. Because SC had direct field experience in child survival activities in its impact communities, the DOH was able to draw on this experience to design more realistic strategies. SC also had greater flexibility, for example in matters which call for fast logistical response, or where the DOH was constrained by its budget. SC was able to step in and help in matters which called for logistical support, such as being able to hire vehicles to transport workshop participants to various CVHW trainings, which may seem minor but often had a major impact on the level of participation. The extensive infrastructure of the DOH provided the means whereby SC could help scale-up best practices by influencing policies and through the financial support of the government.
- Seize every opportunity to strengthen the partnership through other activities or projects even if they are outside the bounds of the partnership. When Save the Children obtained a contract from the Johns Hopkins University (JHU) to develop a model to link child survival and family planning services, a national team was organized. SC and JHU invited the same staff from the DOH who were working on the CVHW project to also be part of the team. Thus, the benefits of integrating child survival and family planning services were used to enhance the design of the DOH CVHW materials.

# Resources

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- Alfiler, M.C. (1984). "Comparative Study of Community Health Programs." Philippines: Panay Unified Services for Health. Unpublished report.
- Caragay, R.M. (1982). "Training Indigenous Health Workers: A Philippine Experience." *World Health Forum*, Vol. 3 (2).
- Chin, F.P. (1993). "Perception of Health Workers and Mothers of the Roles and Functions of Barangay Health Workers in Iloilo: An Exploratory Survey." *Philippine Population Journal*. Vol. 10, Nos. 1-4.
- David, F. and F. Chin. (1993). "An Analysis of the Determinants of Family Planning Volunteer Workers' Performance in Iloilo City." *Philippine Population Journal*, Vol. 9, Nos. 1-4.
- Dayrit, M. M. (1985). "Training Village Health Workers in the Philippines: a Non-governmental Approach." *World Health Forum*, Vol. 6.
- Development Research Initiatives, Inc. (1997). *A Study on Profile of BHWs, their Work Setting and Support System Post Devolution: A Critical Input to the Operationalization of Republic Act 7883*. Philippines Department of Health, Essential National Health Researches. Unpublished report.
- Everett, M. R. (1995), *Diffusion of Innovations* (4th ed.). New York: Free Press.
- Feranil, I.Z. et al. (1989). *Comparative Analysis of Three Types of Integrated Population, Health and Outreach Workers*. University of the Philippines, Population Institute.
- Gladwell, M. (2000). *The Tipping Point*. Boston: Little, Brown and Company.
- Marchione T. (ed.). (1999). *Scaling up, scaling down: overcoming malnutrition in developing countries*. Amsterdam, The Netherlands: Gordon and Breach.



- Philippines Department of Health. (1996). *The Barangay Health Workers' Benefits and Incentives Act of 1995 (RA 7883), Implementing Rules and Regulations*. Manila: Philippines Department of Health.
- Szecsey, C. (1998). *Consultancy Report on Partnering and Institutional Development for Save the Children, Philippine Field Office*. Unpublished report.
- Taylor I., C. Daniel., and C.E. Taylor. (2002). *Just and Lasting Change: When Communities Own Their Futures*. Baltimore: Johns Hopkins University Press.
- United Nations AIDS Programme. (2001). *Reaching Out, Scaling Up: Eight Case Studies of Home and Community Care For and By People with HIV/AIDS*. New York: UNAIDS.

# Additional Resources: Contact Information

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FAO, Via delle terme de Caracalla, 100 Rome, Italy; Fax: 39-6-5225-5514.

Institute of Development Studies, University of Sussex, Brighton BN1 9RE, England, Tel.44-0273-606261.

Institute for Environment and Development, 3 Endsleigh Street, London WC 1 H ODD, UK; Fax:44-171-338-2826.

Jossey-Bass Book Club for Adult Educators, 350 Sansome Street, San Francisco, CA. 94104-1304; Tel: 1-800-956-7739; Fax: 1-800-605-2665; www.josseybass.com

Kumarian Press: International Development; Gender and Development; Health; Government and Environment, 14 Oakwood Avenue, West Hartford, CT. 06119-2127, USA; Tel: 1-800-289-2664; Fax: 1-860-233-6072; email: kpbooks@aol.com

Oxfam: Books on Gender Issues, 1995-96, Oxfam Publishing BEBC Distribution PO Box 1496 Parkstone Poole, Dorset BH12 3YDUK, Fax: (0202) 715556.

Pact Publications, 1200 18<sup>th</sup> Street, NW, Suite 350, Washington, DC 20036, USA; Tel: (202) 466-5666; email: books@pactpub.org

Pamstech House, Woodvale Grove, Westlands, P.O. Box 60054, Nairobi, Kenya.

Pfeiffer/Jossey-Bass, 350 Sansome Street, 5th Floor, San Francisco, CA. 94104, USA; Tel:1-800-247-4434; Fax: 1-800-569-0443.

Sage Publications, Thousand Oaks, CA; email: order@sagepub.com



TALC: Teaching AIDS a Low-Cost, P.O. Box 49, St. Albany, Herts AL1 5TX, United Kingdom, Fax: 44-1727-846852; email: [talcul@btinternet.com](mailto:talcul@btinternet.com)

The Conflict Research Consortium, University of Colorado International Online Training Program on Intractable Conflict supported by the United States Institute of Peace and the William and Flora Hewlett Foundation:  
[www.colorado.edu/conflict/peace/](http://www.colorado.edu/conflict/peace/)

The Training Clinic. [www.apc.net/trainu](http://www.apc.net/trainu); Tel. 1-800-937-4698; Fax: (562) 430-9603; email: [trainu@apc.net](mailto:trainu@apc.net)

# Glossary of Terms

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**Advocacy:** the act of supporting community efforts to obtain resources or change policies.

**Assets-based approach:** an approach in which community members inventory their community strengths and resources so that they can use and build on those strengths and resources to address a health or other issue.

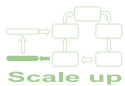
**Autodiagnosis:** a participatory research process in which community groups explore their own health problems in order to raise awareness and understanding of these problems. This process also fosters the community's confidence in their ability to gather information from their neighbors about topics that concern the community and to learn to prioritize the problems that are identified.

**Broader community:** refers to the people in a community who are not directly affected by the problem, but who can indirectly influence the implementation of the CM program and whose perspective and support are needed in order to effectively carry out a community mobilization plan. Examples of the "broader community" include service providers and community leaders.

**Capacity building:** the act of increasing a community's capacity. See "community capacity."

**Catalizer:** a person or organization that works directly with existing leaders and community groups to stimulate or precipitate action.

**Community:** refers not only to a group of people who live in a defined territory, but also to groups of people who may be physically separated but who are con-



nected by other common characteristics, such as profession, interests, age, ethnic origin, or language.

**Community action cycle:** a sequence of phases a community goes through in order to carry out long-term, sustainable development. The steps of the community action cycle are: 1) organize the community for action; 2) explore health issues and set priorities; 3) plan together; 4) act together; and 5) evaluate together. The process described in this field guide adds a preparing phase and a scaling-up phase.

**Community capacity:** the skills, knowledge, and expertise of community members which individually and collectively constitute a community's ability to identify and address its needs.

**Community development:** a process of identifying community leaders, organizing groups or building on existing groups and training these groups and individuals to assess their needs and resources; prioritizing a list of problems that can be addressed; planning a project or an activity; obtaining resources to implement the plan; taking actions; and evaluating their impact using the lessons learned to begin the cycle again. Community development takes into account, and is influenced by, the external environment including macroeconomic and political realities and global trends.

**Community empowerment:** a process by which groups of individuals, organizations, and communities are enabled and share “power” to collectively analyze problems, propose solutions, mobilize and manage resources and act effectively to transform their lives and their environments.

**Community mobilization program team:** made up of individuals from one or more external organizations who work directly with existing leaders and community groups to stimulate or precipitate the community mobilization effort. This team (referred to as the program team in this field guide) facilitates the CM process, provides support and advise to and helps build the capacity of the core group and broader community.

**Community organizing:** involves organizing or strengthening community-level individuals, groups and/or organizations. Community organizing may occur around a specific purpose or may be part of a broader community development process.

**Community participation:** a social process whereby specific groups with shared needs, often but not always living in a defined geographic area, actively pursue identification of their needs, make decisions and establish mechanisms to meet these needs. Community members' participation in a program or activity can be thought of in terms of a continuum from minimal to very high. At the low end, community members may attend an event such as a health fair that has been planned and carried out by health service providers. At the higher end, community members may identify the need for family planning methods and information, petition the ministry of health to request services and supplies, train local community members to distribute methods and manage their own supplies fund and inventory, and so forth.

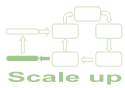
**Community team:** see core group.

**Core group:** a group of individuals who lead the mobilization effort on behalf of the community. Also referred to as the community team.

**Mobilizer:** see catalizer.

**Nonformal education:** out-of-school learning that both facilitator and participants plan and agree upon and is learner-centered and experienced-based. Learners are encouraged to explore their own reality on the basis of personal experience and voice their own ideas as they work to solve their own problems. It is also known as popular education.

**Participatory learning in action (PLA):** a community development approach whereby facilitators work with communities to help them analyze their needs, identify solutions to fill those needs, and develop and implement a plan of action.





It is based on many different participatory approaches including PRA and RRA (see below).

**Participatory research:** a method of research in which community members participate to varying degrees in question formulation, design of methods and instruments, and conduct analysis or research and evaluation. This type of research can raise awareness of issues and provide information around which to develop action plans. RRA, PRA, autodiagnosis, and PLA are examples of participatory research methodologies and techniques.

**Participatory rural appraisal (PRA):** a family of approaches and methods to enable rural people to share, to enhance and analyze their knowledge of life and conditions, to plan and to act.

**Partner:** in this context refers to any formal organization or entity working with any other organization or entity to carry out community mobilization.

**Popular education;** see nonformal education.

**Positive deviance approach:** this approach seeks to help communities identify those who are healthy, study their healthy behaviors and practices, and enlist them to model positive behaviors for others who are not practicing these behaviors.

**Problem-posing approach:** stems from Paolo Freire's methods used to raise awareness of social problems and injustice to incite action of marginalized or disadvantaged groups. The process is rooted in problem analysis, reflection, and action.

**Program team:** see community mobilization program team above.

**Qualitative indicators:** indicators that measure the quality of change or improvement.

**Quantitative indicators:** indicators that can be measured or expressed as a quantity or in numbers.

**Rapid rural appraisal (RRA):** a qualitative methodology used to gather information during (relatively) short but intensive studies in the field. A multidisciplinary team makes use of a range of tools and techniques that encourage local participation in the research process and facilitate the sharing of knowledge.

**Scaling-up:** expanding community participatory approaches beyond a single or limited number of communities to have greater impact at the regional, national or even multinational level without diminishing the quality or impact of the approach.

**Social marketing:** the application of marketing technologies developed in the commercial sector to the solution of social problems where the bottom line is behavior change. (Adapted from Andreasen, 1995.)

**Social mobilization:** the process of bringing together all feasible and practical intersectoral social allies to raise people's awareness of and demand for a particular development program, to assist in the delivery of resources and services, and to strengthen community participation for sustainability and self-reliance. (McKee, 1992)

**Strength-based approach:** identifies and emphasizes the positive aspects of a community's assets and work on an issue or existing behaviors that promote health and well-being. Strength-based approaches promote hope and seek to increase self-efficacy by emphasizing and building upon what individuals and groups have accomplished using their existing resources, skills, and abilities and by de-emphasizing blame for existing problems.

**Sustainability:** the quality of a development effort wherein the results/benefits of that effort continue to perpetuate themselves after the initial external inputs have been removed.

