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
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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. 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.

- **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.

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1 Focus on Young Adult: Getting to Scale in Young Adult Reproductive Health Programs: A Synthesis of Experience, June 1999.

2 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.3

**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.

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3 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.
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.

**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.
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.
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 re-
ponses 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 guid-
ance 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 Techni-
cal 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?”

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.

For community mobilization approaches to be effective, potential partners must be convinced of the capacity of communities to improve their health.
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
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
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
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 website 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 Barangy 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.


Additional Resources: Contact Information

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 18th 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
Glossary of Terms

**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-
connected 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.