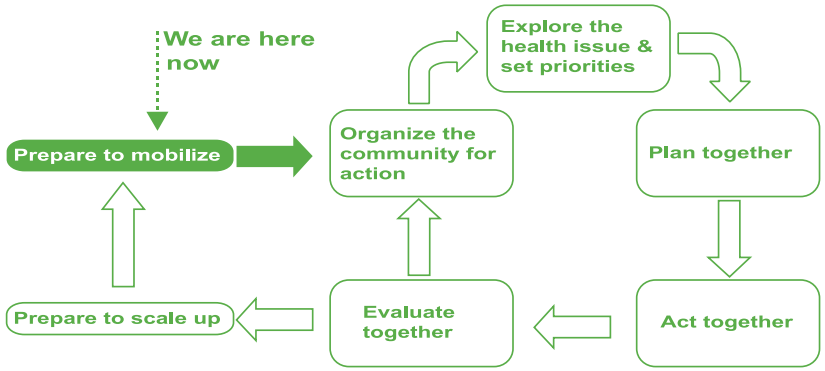
Chapter 1

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 a 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.

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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:

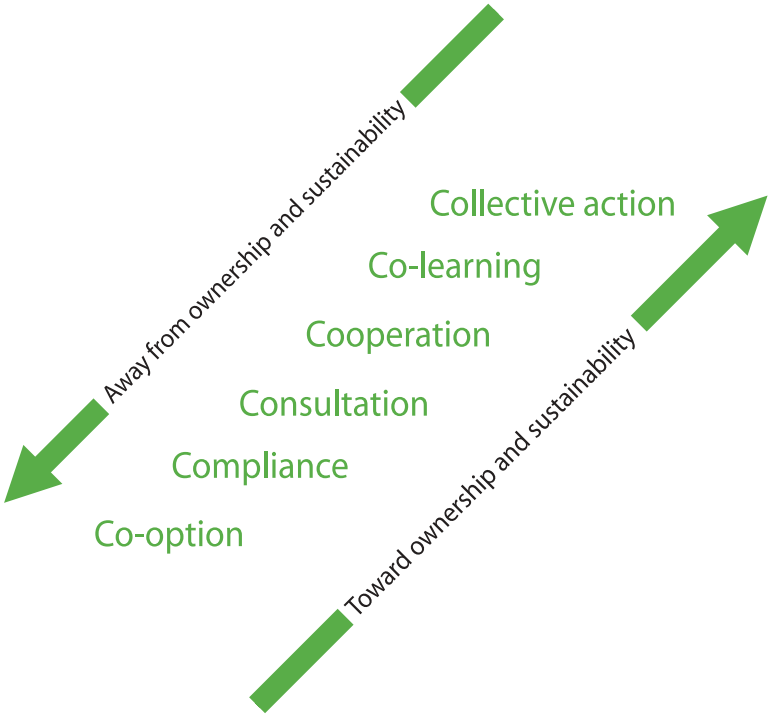
- The problem may be perceived to be the norm (e.g., stunting from malnutrition).
- The problem may be a silent epidemic, such as HIV/AIDS.
- The problem may be experienced by those in the community who have little or no voice in community decision-making (e.g., social castes, the poor, women, the geographically 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.

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[1]

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

[1]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.

- ***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.

Prepare to Mobilize

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.

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.

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

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,[2] national statistics, studies and surveys, PVO/NGO data and reports, facility-based service and coverage data.

[2] 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; Email: 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,[3] Health Facility Assessment Tool,[4] cluster surveys, and household surveys. For more information about these tools, see the resource guide at the end of this chapter.

[3]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; E-mail: pubinfo@popcouncil.org.

[4]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; E-mail: 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).

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.

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

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

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
• Power	• Create a more equitable balance of power between communities and service providers
• Respect	• Develop mutual respect
• Self-esteem	• Build self-esteem (of both community members and service providers)
• Gender	• Ensure that women are active participants in the process
• Quality (central theme around which to mobilize)	• Shift concept of quality from service-based to "quality begins at home"…services are only one component of quality care
• Rights and responsibilities	• Shared responsibility for health
• Differing paradigms/belief systems (western medicine vs. indigenous knowledge)	• Acceptance of differing perspectives; dialogue to maximize benefits of positive, healthy beliefs and practices regardless of origin
• Team work	• Encourage development of a team
• Critical self-reflection and objectivity	• Foster environment that promotes critical self-reflection and objectivity
• Protagonism	• Foster protagonism (communities and providers set agenda, implement, monitor, and evaluate their progress)

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: 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 the 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.

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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!

Prepare to Mobilize

Useful Tools

1. 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 socioeconomic 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.[5]

[5] 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.

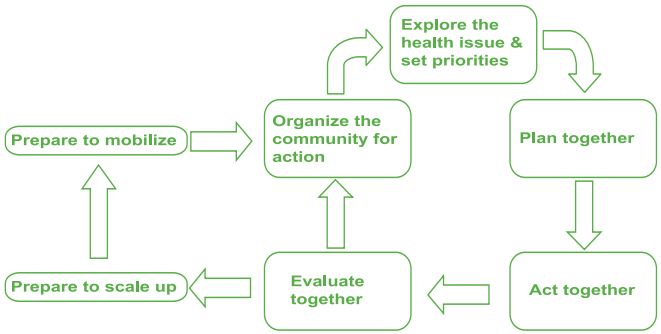
3. Program Objectives

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

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

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

General

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