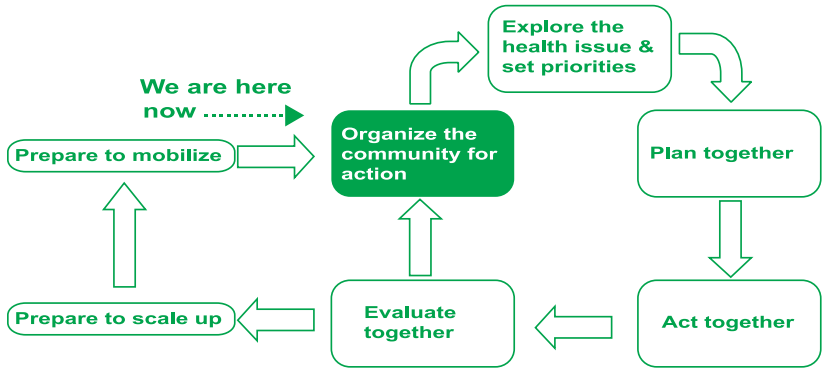
Chapter 2

Organize the Community for Action

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



> "As an individual I could do nothing. As a group we could find a way to solve each other's problems."
>
> Community member, Rwanda

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

STEP 1: Orient the community.

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

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

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

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

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

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

Most orientation sessions include, at a minimum:

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

An Example of Organizing around Role Models

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

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

Be careful not to preempt the community

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

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

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

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

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

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

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

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

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

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

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

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

STEP 3: Invite community participation.

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

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

VIETNAM: Humor

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

Monique Sternin, SC Vietnam

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

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

MOZAMBIQUE: Building Trust

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

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

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

Save the Children Federation (US), Mozambique field office

- The program team identifies community organizations that are already working on health issues and asks to be included on the agenda for an upcoming meeting. Those who attend the meeting are already engaged in similar activities and may or may not be directly affected by the specific CM health issue. This approach limits the initial group of attendees to those who are already interested in similar issues.

- The program team undertakes a study of social networks in the community to identify those key people who communicate with and influence many others on subjects like the CM health issue. These individuals are then invited to a community organizing meeting, along with others who are interested in or affected by the issue.

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

Factors which influence participation[1]

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

Community-related factors

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

SENEGAL: The Importance of Grandmothers

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

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

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

RWANDA: The Dependency Syndrome

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

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

Save the Children Federation (US), Rwanda field office

- Prior community action: the extent to which collective action, in general and/or specific to the issue, has previously occurred in the community. This factor is sometimes called collective efficacy, the belief that the group/community is capable of accomplishing a task by working together. It is obviously influenced by some of the previous factors.

- Subjective norms: refers to perceptions of what other people do or think should be done about a particular issue, including the perception of how acceptable collective action is on this issue.

Personal factors

- Personal involvement: the degree to which people have direct personal experience with an issue.

- Perceived self-efficacy: refers to a person's belief that he/ she is personally capable of performing a particular task.

- Prior personal participation in collective action: the number of times people have done something as a group, either in a generic sense or with regard to the issue at hand.

- Strength of identification with the community: the degree to which people recognize the group affected by an issue as a community, and/or the degree to which they feel they belong to the group affected by the issue in question.

- Perceived consequences of change: refers to an individual's perception of what the consequences of change are vis-à-vis the issue. What will happen to me if I do this? If I don't? If my community does/does not? What are the costs and benefits for me/my community?

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

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

Raising awareness

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

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

- Identifying those individuals and groups that have the most direct experience with the CM health issue, even if there may only be a small number who want to participate at first.

- Launching a general awareness campaign through local media, community meetings, enlisting spokespeople, and so forth.

VIETNAM: Meeting with the Community

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

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

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

Save the Children Federation (US), Vietnam field office

- Advocating the importance of the CM health issue with local leaders, using data, studies, critical incidents (such as death or illness), and other means so that local leaders put the CM health issue on their agenda.

- Sharing comparative data with the entire community on the prevalence of the CM health issue in their own community relative to other communities to emphasize the need for action.

Overcoming barriers and resistance to participation

Undoubtedly, it would be easier for your team to work only with those people who show up in response to a general announcement ("rounding up the usual suspects"), but this strategy may not be the wisest or most effective if you truly want to reach priority groups. There are many reasons people may not want or be able to participate in the community mobilization process. We believe that people should be free to decide whether or not they want to participate. There are times, however, when people genuinely want to participate but are unable to because of certain barriers. Knowing about these barriers and devising ways to overcome them can yield obvious benefits. Among the most common barriers:

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

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

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

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

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

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

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

The power of groups

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

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

An old group or a new group?

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

The *advantages* of using existing groups include:

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

Using existing groups also has certain *disadvantages*:

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

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

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

Strategies for identifying and recruiting core group members

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

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

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

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

Developing the core group

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

Groups That Work

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

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

Designing Community Based Development , World Bank, 1999.

The Tuckman Model of group development

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

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

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

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

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

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

The role of leaders and external facilitators in group development

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

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

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

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

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

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

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

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

Core group norms

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

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

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

Documenting core group and other meetings

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

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

Assessing and monitoring core group capacity

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

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

Suggested indicators for assessing a group's capacity for collective action include[2]:

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

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

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

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

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

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

Useful Tools

1. Checklist for Community Organizing

(Step 1, page 62)

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

1. How has the community organized collective action in the past?

2. What is the main purpose of the community organizing phase for this program? (It may be helpful here to refer to the underlying themes or causes you identified in chapter 1.)

3. What are the possible benefits and consequences of working within the traditional structures? Can the underlying themes be addressed by working through these structures or do you need to think of alternatives?

4. What is the overall approach that you have decided to adopt for this program (problem-posing, strength-based, mixed, top-down or bottom-up)?

5. How will this approach be applied during the community organizing phase?

6. What is your team's role in the community organization process (direct implementation, training and providing technical assistance to community organizers, other)?

7. How do you plan to orient the general community to the CM program?
8. Who do you want to know about the program?

9. Which are the individuals, groups, and organizations you most want to reach and should invite to participate in the community mobilization process? Why?

10. Who will organize the general community orientation process?

11. How will organizers orient the general community about the program? (Consider strategies, methods/media, timing, and other issues.)

II. Planning Checklist for a Community Meeting

(Step 1, pages 63-65)

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

- **Participants:** How many participants are expected? Who will they be? (Consider total number, ratio of men to women, language(s) they speak, level of education, prior experience working in groups in general and working together in this group, social status/relationships, age, relationship to the issue.)

- **When:** The time, date, and length of the meeting should be convenient for the invitees. This point may seem obvious, but many teams continue to schedule meetings at times that are convenient for them but not for community members, which can limit participation. Additionally, community members should be invited with ample time before the meeting so they can plan to attend.

- **Where:** In some cases, there is little choice of venue as there are a limited number of community meeting places. When choice exists, the team should

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

- **Agenda:** What are the objectives of the meeting? Which topics will be covered? In which sequence will topics be introduced? How much time will be dedicated to each topic? Is the time allocated sufficient and in line with meeting priorities and objectives?

- **Speakers/facilitators:** Who will run the meeting? Who will be asked to prepare and/or present information for the meeting?

- **Methodology/tools/techniques:** How will participation be encouraged and supported?

- **Documentation of meeting process and outcomes:** It is helpful to document what happens during meetings for many reasons, including:

    - To help participants and others learn from experience.
    - To orient new participants on what has happened in the past.
    - To resolve disputes or misunderstandings about decisions or actions.
    - To serve as a resource to evaluate programs.

- **Materials needed:** The materials needed will depend on the methods that will be used. Many facilitators ensure that paper, markers and tape (or other ways to hang up paper such as nails) are available. Additionally, you will need to review each session of the agenda to determine whether other materials need to be prepared.

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

(Step 4, pages 81-83)

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

How to use this tool

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

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

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

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

Community management and participation

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

1. **Needs Assessment:** This category measures the community's planning skills and specifically their experience and involvement in goal setting and problem solving. It also measures their diagnostic skills, particularly the degree of understanding of cause-effect relationships (i.e., the linkage between poor water and disease or income shortages and seasonal agriculture).

2. **Consciousness:** This category describes the community's willingness to effect change. It measures their willingness to plan for the future, particularly beyond their immediate, cyclical or seasonal needs and also relates to a group's receptivity to ideas, opinions, and critiques from the outside.

3. **Programmatic Involvement:** This category describes how the community is involved in development activities. It focuses on the community's role in and degree of responsibility for project administration, maintenance, and evaluation. Over time it tracks the community's decreasing reliance on external assistance in key areas of program and project management. (Dependence on financial resources is covered in Section 6 on the next page.)

4. **Organization:** This component describes the structures for decision-making and the mechanisms for articulating community and individual needs and preferences. Structures/mechanisms may be formal or informal, hierarchical or participatory, legally recognized with explicit operating policies and procedures or otherwise. They may be organized by project, interest group, community, impact area, or region.

5. **Participation:** This category is defined by two dimensions. The first describes who in the community is actively taking part in and sharing in development activities. It measures the degree to which targeted groups, including the disadvantaged and poorer strata of the community, women, children, and youth, are meaningfully brought into the decision-making process related to project planning, implementation, and evaluation. The second dimension of this component measures the distribution of benefits among individuals and groups, especially those with limited means and opportunities to promote their own interests.

6. **Financial Management Capacity:** This category is a composite of three related factors measuring the community's desire and ability to contribute significant resources to their own development. In the first instance it measures the level of community cash and in-kind investment. Secondly, it assesses the local group's (i.e., committee's or council's) credibility in the opinion of the community in managing these and other funds. Finally, this category measures the local group's skill level in managing funds under their control.

7. **Linkages:** This category measures the mobilization of resources to support the community's development priorities and includes measuring the increasing utilization of internal (community level) resources. It also measures the community's awareness of external resources/opportunities and their ability to obtain these resources/opportunities (i.e., credit, skills training, extension services) on favorable terms from a system that has by and large ignored them.

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

Score (1-5) for this indicator:	
YEAR 1	
YEAR 2	
YEAR 3	
YEAR 4	
YEAR 5	

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

Score (1-5) for this indicator:	
YEAR 1	
YEAR 2	
YEAR 3	
YEAR 4	
YEAR 5	

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

Score (1-5) for this indicator:	
YEAR 1	
YEAR 2	
YEAR 3	
YEAR 4	
YEAR 5	

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

Score (1-5) for this indicator:	
YEAR 1	
YEAR 2	
YEAR 3	
YEAR 4	
YEAR 5	

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

Score (1-5) for this indicator:	
YEAR 1	
YEAR 2	
YEAR 3	
YEAR 4	
YEAR 5	

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

Score (1-5) for this indicator:	
YEAR 1	
YEAR 2	
YEAR 3	
YEAR 4	
YEAR 5	

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

Organize the Community for Action

Score (1-5) for this indicator:	
YEAR 1	
YEAR 2	
YEAR 3	
YEAR 4	
YEAR 5	

COMMUNITY MANAGEMENT AND PARTICIPATION: *Seven Assessment Criteria*

ASSESSMENT CRITERIA	1	2	3	4	5	6	7	TOTAL
YEAR 1								
YEAR 2								
YEAR 3								
YEAR 4								
YEAR 5								

Resources

Bhattacharyya, K. and J. Murray. (1999). *Participatory Community Planning for Child Health: Implementation Guidelines.* USAID/BASICS Project.

Christian Reformed World Relief Committee. (1997). *Partnering to Build and Measure Organizational Capacity: Lessons from NGOs Around the World*. Grand Rapids, MI: Christian Reformed World Relief Committee.

Fiagbey, E. et al. (2000). *CHPS Implementation Guide: Formation of Community Health Committees*. Baltimore: Johns Hopkins University Center for Communication Programs/Ghana.

Goleman, D. (1998). "What Makes a Leader?" *Harvard Business Review*, November-December, pp. 93-102, (Reprint 98606).

Green, C. (1998). *Mother Support Groups: A Review of Experience in Developing Countries.* USAID/BASICS Project.

Heaney, C.A. and B.A. Israel. (1997). *Social Networks and Social Support in Health Behavior and Health Education: Theory, Research, and Practice*. San Franscisco: Jossey-Bass, pp. 179-205.

Hope, A. and S. Timmel. (1986). *Training for Transformation, Book 3*. Gweru, Zimbabwe: Mambo Press, pp. 101-102.

Hyma, B., and P. Nyamwange. (1993). "Women's role and participation in farm and community tree-growing activities in Kiambu District, Kenya." In J. Henshall Momsen and V. Kinnaird (eds.), *Different places, different voices: Gender and development in Africa, Asia and Latin America.* London: Routledge.

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

Kormanski, C. (1985). "A Situational Leadership™ Approach to Groups Using the Tuckman Model of Group Development." *Developing Human Resources*. San Diego, CA: University Associates, pp. 217-224.

Leach, M. (1994). "Building Capacity Through Action Learning." *IDR Reports,* Vol. 10 (5): 1-29.

MAP International. (1997). "Community Participation Assessment Tool." Presented at a Community Mobilization workshop sponsored by Johns Hopkins University Center for Communication Programs and Save the Children/US, Cochabamba, Bolivia.

Minkler, M. (ed.). (1997). *Community Organizing and Community Building for Health*. New Jersey: Rutgers, The State University.

Rivera, A., et al. (1993). *The Promotion of the Lactational Amenorrhea Method and Child Spacing through Breastfeeding Advocates*. Washington, DC: Georgetown University Institute for Reproductive Health.

Rivera, F., and J. Ehrlich. (1995). *Community Organizing in a Diverse Society*. Boston: Allyn and Bacon.

Rosenberg, J.E. and M.J. Joya de Suarez. (1996). *Community-based breastfeeding support: A guide for trainers and supervisors*. Washington, DC and San Diego, CA: Expanded Promotion of Breastfeeding Program, Wellstart International.

Spencer, L.J. (1989). *Winning Through Participation Meeting the Challenge of Corporate Chance With the Technology of Participation*. Dubuque, IA: Kendall/Hunt Publishing Co.

Storms, D. (1998). Personal communication on support groups as a health intervention reported in Green, C. P. (1998). *Mother Support Groups: A Review of Experience in Developing Countries.* USAID/BASICS Project.

USAID. (1999). "HIV/AIDS: Care and Support Initiatives via Community Mobilization." *Displaced Children and Orphan Fund Synthesis Paper*. Washington, DC: USAID.

World Bank. (1999). "Designing Community Based Development." *Environment Department Dissemination Note*, Number 17.