Reflections on Two Decades of Community Empowerment & Current Challenges in the Field

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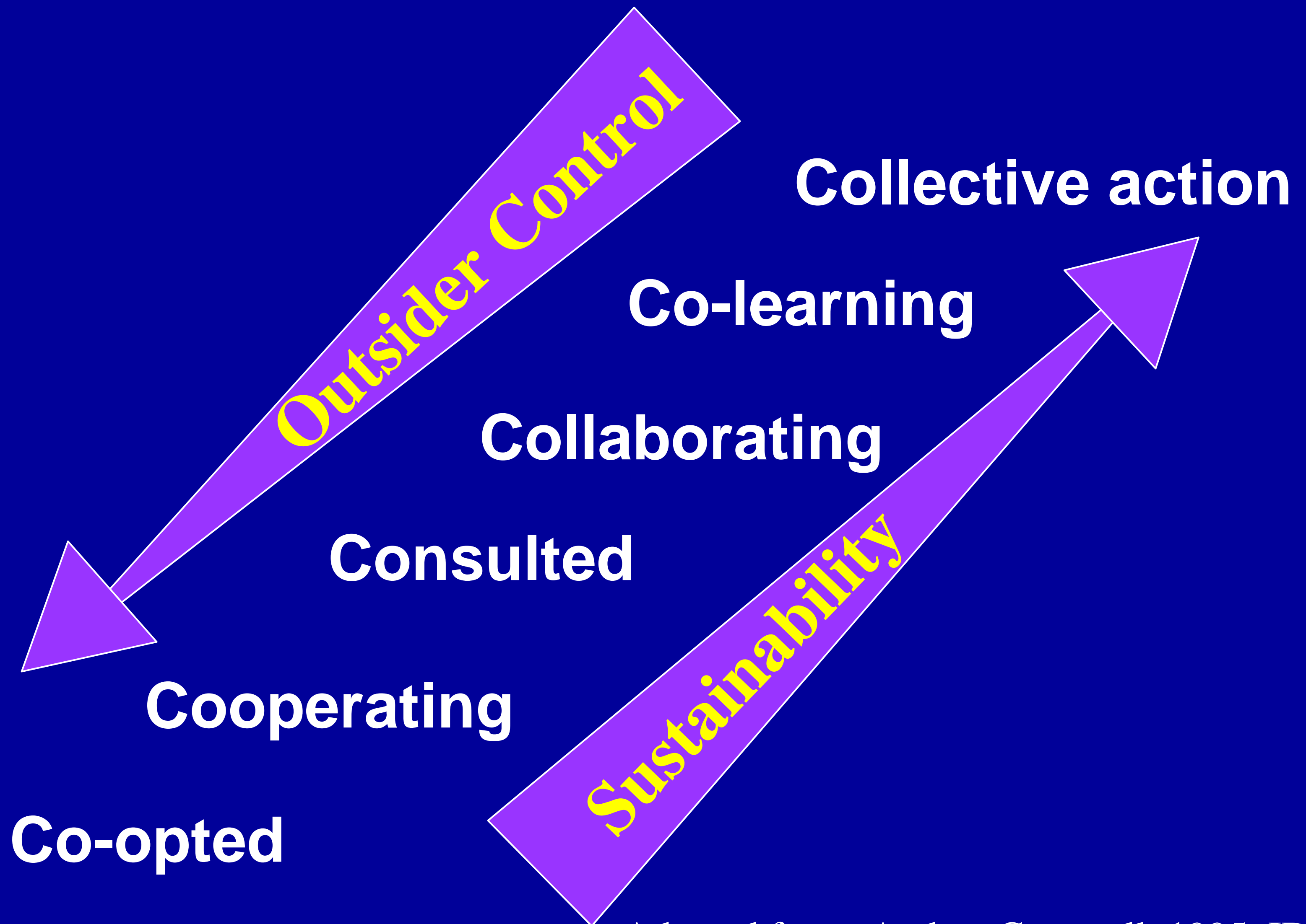
Community Mobilization Operational Definition

- 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.

What is community?

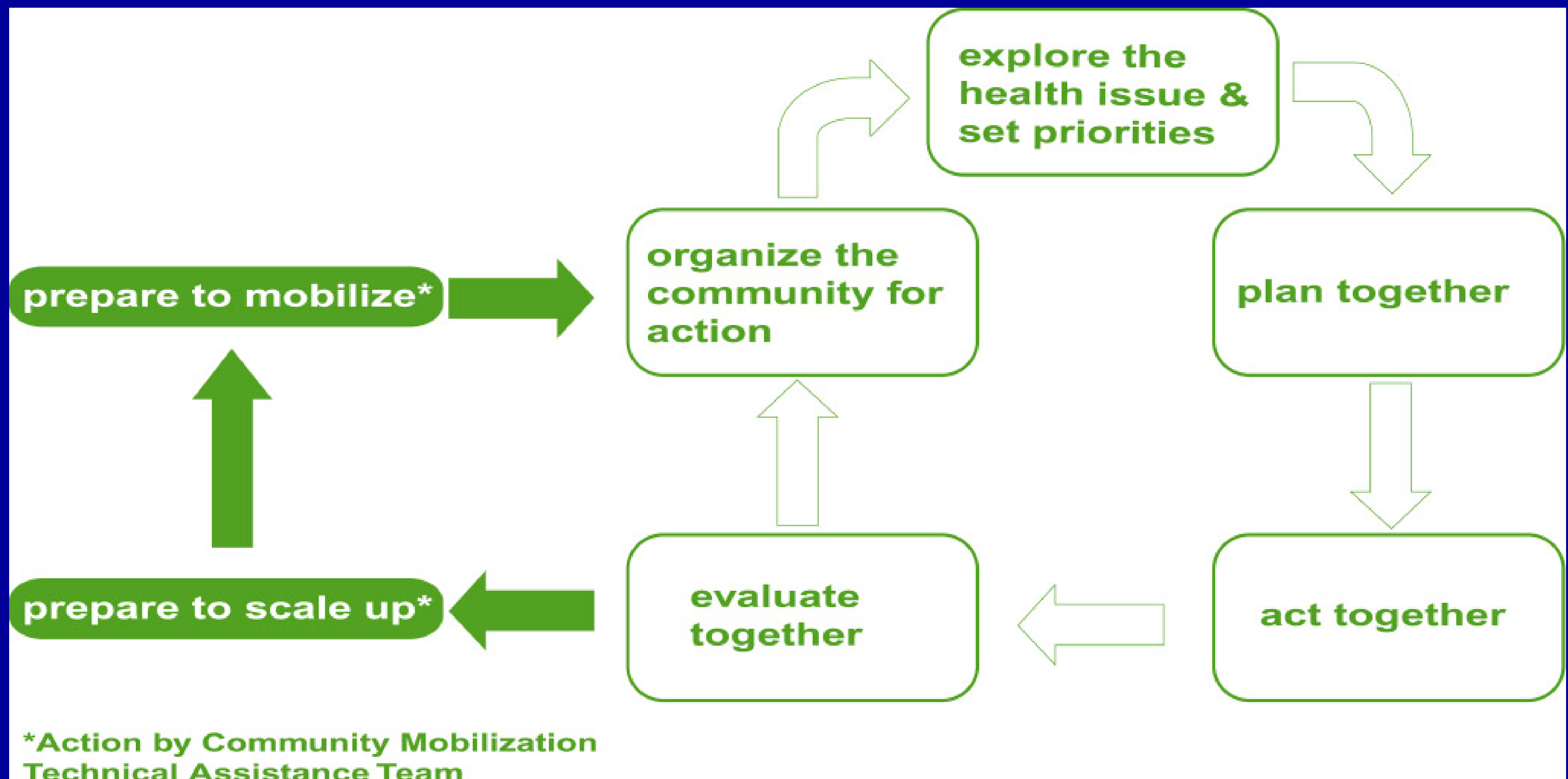
- Geographically defined
- Shared interests, identity and/or characteristics
- Shared resources

Dimensions of Community Participation



Adapted from: Andrea Cornwall, 1995, IDS

A Community Action Cycle



Evaluating CM programs

Community mobilization programs are now attempting to measure & document:

- Health outcomes
- Community competency, capacity, and empowerment outcomes in various domains (Goodman, Laverack, etc.)
- Linkages/relationships between communities, service providers, other organizations, networks, coalitions, donors & government

Community Mobilization & Empowerment

Four Case Studies 1990 - 2007

Warmi Project

Save the Children & JSI/MotherCare, USAID-supported
(Demonstration project 1990 – 1993; "Scaled-up" 1994- present)

Project Goal

To improve maternal and neonatal health in the 50 participating communities.

The Setting: Inquisivi Province, Bolivia

- 50 rural, dispersed communities (project pop. 15,000) in former mining area no economically depressed with inhabitants living in extreme poverty
- Three geographically distinct zones (high plains, valley and subtropical)
- Women geographically and culturally isolated
- Languages: Aymara, Quechua and Spanish
- Aymara culture has survived by resisting change

Baseline Health Indicators

- Maternal mortality estimated at 1,400/100,000 births (3 times greater than the national rate)
- Perinatal mortality estimated at 103/1,000 births
- Neonatal mortality estimated at 69/1,000 live births

Health Services

- Poor quality health services

  (1 Health Post per Zone and a District Hospital)
- Labor/delivery complications referred to La Paz or Oruro (5 to 6 hrs away)
- No family planning services
- Husbands attended births

Baseline Research

- Retrospective Case-Control Study of maternal, perinatal and neonatal mortality

  (cases- died, controls- did not die)

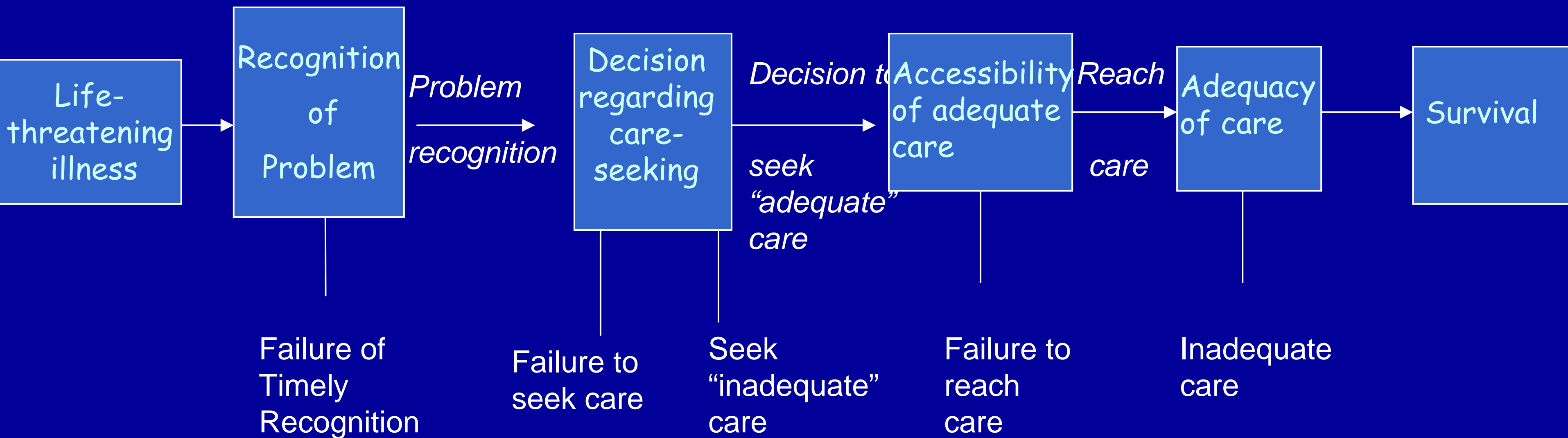
  MAJOR FINDINGS:

  – No major differences between "cases" and "controls" (slightly higher risk for single mothers and women with history of obstetric complications)
  – Over 70% of deaths occurred in families that did not recognize a problem or realized too late.

Baseline probable causes of perinatal & neonatal mortality

- Asphyxia (25%)
- Asphyxia &/or trauma (8%)
- Trauma (5%)
- Hypothermia (5%)
- Unwanted child/uncared for (3%)
- Sepsis (10%)
- Pneumonia (4%)
- Tetanus (4%)
- Hypertensive disease (4%)
- Hemorrhage (10%)
- Maternal death (3%)
- Others (19%)

The Warmi Project "Pathway to Survival"



Initial Phases

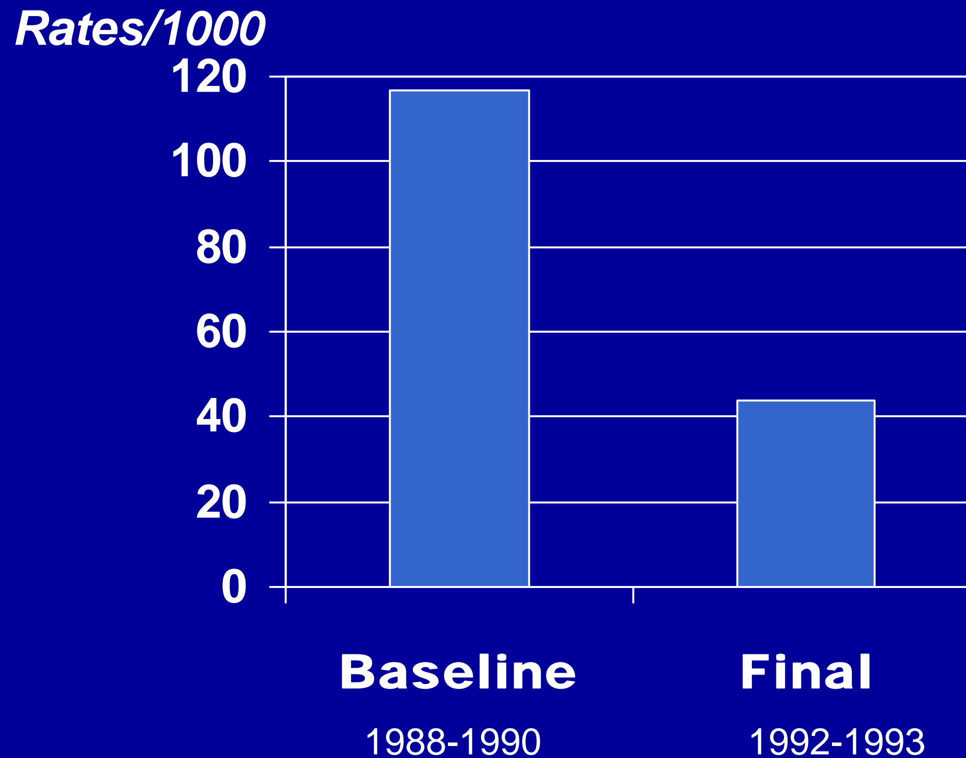
- Organized and strengthened women's groups
- Conducted "autodiagnosis"
- Conducted "planning together" session

[video 4:08-11:13]

Strategies & activities implemented by communities

- Improved women's status- participation in community decision-making fora.
- TT2 for mothers
- Identified and trained midwives & family members to attend births
- Strengthened referral links with San Gabriel Hospital
- Women's credit program
- Literacy program
- Made & sold mosquito nets
- Increased prenatal care; iron
- Family planning
- Health education- "dialogue of knowledge" & materials (booklets, midwives manual)
- Transport agreements
- Emergency funds
- Women's health card, prep for pregnancy/birth
- Women's group pressure on families to seek care when danger signs occurred
- Made & sold clean birth kits

Perinatal/Neonatal* Mortality



*Died within 28 days of birth

χ^2: $P<0.001$, 1 df.

Scaling Up *Warmi*

- The *Warmi* methodology was expanded in 1995 to national level through NGO and government partners' efforts in 8 of Bolivia's 9 Departments, reaching over 500 of the most marginalized communities and over 200,000 women of reproductive age.

KEYS TO SUCCESS OF THE WARMI PROJECT

START FROM EXISTING HEALTH BELIEF SYSTEMS & PRACTICES

- All participants learned about existing practices and beliefs and the "whys" behind them using participatory methods.
- Beneficial or benign practices were respected.
- When existing practices were harmful, providers and project staff introduced "recommended" practice. Project team, service providers and women's groups negotiated "new, improved" behaviors through facilitated "dialogue of knowledge".

CROSS-SECTORAL INTEGRATION

- Recognized the importance of other sector activities in improving health (economic opportunities, literacy/education, etc.) and partnered with other organizations to be able to link communities with these programs.

PARTICIPATION

- **At all levels, throughout the process:**
  - **Community**
  - **Health services**
  - **Project team**
  - **Current and future partners**

FACILITATE,

DON'T FACIPULATE!

BE FLEXIBLE.

GENDER SENSITIVITY

Women and men had important roles:

- Involved men in the process in a meaningful way that increased their interest and participation in the topic.
- Organizing & strengthening women's groups gave women a voice in the community and reduced isolation.

USE DATA FOR DECISION-MAKING

- Quarterly evaluation and planning sessions with review of status on indicators.
- Remained flexible and encouraged creative responses when strategies weren’t working.
- Returned to communities to seek advice when things did not go as planned.

EMPHASIS ON SUSTAINABILITY

- SC refused to establish a long-term role that would create dependency or that would relieve other local organizations (including MOH) of their responsibility to provide services to the population.
- Additionally, Warmi methodology aimed at skills strengthening and organization--both necessary for longer-term impact.

MIRA RCT, Nepal

Results of first MIRA Trial in 6 districts of Makwanpur, Nepal

- 30% decline in newborn mortality
- Maternal Mortality Ratio:
  69/100,000 l.b.- intervention communities
  341/100,000 l.b.- control communities.
- Many examples of community capacity to take collective action to improve health similar to *Warmi* experience.
- Two years post-project, 105/111 groups still meeting regularly with local women facilitating and no external assistance.

Building on *Warmi* approach

- Community-based health information system to strengthen joint planning and monitoring ("SECI")
- Partner-defined quality (Nepal "PDQ" and Peru *Puentes* "Building Bridges for Quality")
- Appreciative Community Mobilization

Community-Based Health Information System ("SECI")

- Health promoters collect data on key indicators from families monthly
- Service providers collect service utilization data
- Together they consolidate data at the end of the month.
- The SECI team uses simple tools to share the data with the community.
- Community members review and analyze the information.

SECI Process--cont'd.

- Participants then set priorities and develop plans to improve their priority health indicators.
- They monitor their progress every month and adjust their strategies.

Examples of SECI Outcomes

- Greatly improved child survival indicators (vaccination, Vit A, breastfeeding, detection & treatment ARI, etc.).
- Strengthened community capacity to collect, analyze and use data; plan & negotiate with service providers; take collective action and carry out community advocacy at municipal & district levels.

Partner-Defined Quality

- Perú (*Puentes*, Building Bridges for Quality)
- Nepal (PDQ)

Puentes Steps

- Establish local MOH sub-regional team
- Select pilot areas
- Train local MOH team
- Select community & provider participants
- Produce participatory videos with communities and providers (separately)
- Initiate respectful dialogue that results in joint action plan
- Implement plan
- Monitor progress together
- Evaluate results together (after one year)

Example of progress on a community action plan

Planned	Accomplished
Replacement of Midwife	Nursing technician is hired
Access to MD specialist	OBGYN/Pediatrician visit community
Available & affordable drugs	Increased stock of drugs
Purchase of medical equipment, supplies and materials	Post is equipped adequately
Rapid attention	Waiting time is reduced
Access to 24 hours service	24 hrs emergency service is established
Access to transportation	Motorcycle for home visits & emergencies

Where Partner Defined Quality has been implemented

Africa

- Kenya (Busia)
- Mozambique (14 districts)
- Uganda (4 districts)

Asia

- Nepal (50 Village Development Committees)

Latin America

- Bolivia (Oruro, adolescent health)
- Peru (Puno)

Middle East/Eastern Europe

- Georgia (Tblisi)
- West Bank/Gaza

Others?

Appreciative Community Mobilization for Family Planning, Child Survival & Coastal Conservation in the Philippines

DISCOVERY
"What gives life?"
APRECIATING

DREAM
"What might be?"
ENVISIONING IMPACT

The 4D Cycle

DESIGN
"What should be -- the ideal?"
COONSTRUCTING

DESTINY
"How to empower, learn, and adjust/improvise?"
SUSTAINING

Philippines ACM Individual/Family Outcomes

KSP

- Use of many maternal health services significantly increased in both urban and rural populations.
- All child immunizations steadily increased for marginalized rural groups.
- Appropriate treatment of diarrheal disease was significantly higher for rural marginalized populations

PESCO-Dev

- Contraceptive prevalence rates in project sites increased by 7 percentage points compared to 4 points in the region
- Participating municipalities established 18 marine-protected areas providing 903 hectares of fish sanctuary.
- Overall, participating communities in integrated PHE efforts demonstrated higher levels of contraceptive use, FP utilization, and improved coastal resource management practices.

Philippines ACM Community Outcomes

KSP

- All communities developed action plans; 92% completed on time.
- Of the 232 KSP team members trained, almost 2/3 members came from the *sitios* (neighborhoods) where they represented a majority of marginalized groups. Many assumed leadership positions.

PESCO-Dev

- LGUs located in municipalities passed 87 PHE resolutions, leading to formation of PHE technical working groups, standards for reproductive health facilities, and LGU budget allocations of approximately $62,000 for PHE *(Pasion & Mendoza, 2002).*
- Formed national-level PHE coalition of 200 local and international NGOs. *(Pasion & Mendoza, 2002.*
- First national PHE conference took place in 2004. Local and national leaders effectively advocated for mainstreaming the PHE agenda into national environment and health policies.

Philippines ACM Scale-Up Timeline

PROGRAM	PROVINCES	MUNICIPALITIES	POP. COVERAGE
KSP/Family Health pilot — mid-1997	1	16	30,400
KSP at end of pilot — 2002	1	22	65,000
PESCO Dev and expansion under ANIHEAD — 1999 - 2004	1	11 +	428,475
EnRich — 2002 - 2006	1	10 +	337,338
LEAD for Health — 2004 - 2007	3	750 +	2,109,388

Where in the World is the Community Action Cycle?

Countries

Africa: Angola, Burkina Faso, Cameroon, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Sudan, Tanzania, Uganda, Zambia

Asia: Bangladesh, India, Indonesia, Nepal, Philippines

Eastern Europe: Armenia

LAC: Bolivia, Brazil, Ecuador, Guatemala, Peru

Middle East: Egypt, Jordan, West Bank/Gaza

Others?

Topics

- Maternal Health
- Newborn Health
- Family Planning
- Child Survival
- Adolescent RH/sexual health
- HIV/AIDS & OVCs
- Malaria & TB
- Population & Environment
- Nutrition
- Food Security
- Education
- Female Genital Cutting
- Violence against women
- Post-abortion Care
- Women’s rights

Summary

Community empowering programs, when designed & implemented thoughtfully are…..

- Effective in improving health outcomes
- Effective in strengthening community capacity
- Replicable and adaptable
- Able to expand to large scale
- Cost effective (more data needed here, but so far, costs documented have been within acceptable ranges)

Lessons Learned & Current Challenges

- What have you learned about how to develop, support and evaluate community empowering programs for health?

- What major challenges do we face today?
- What questions, doubts, fears and concerns do you have about how to develop and support these programs?
- What are the questions we need to be asking ourselves now?

Lessons Learned

- Principles of community ownership and empowerment are foundational to this process. Meet people where they are and trust them to make their own decisions.
- Be well-informed about the process. Read and discuss as much as you can to gain a solid understanding of what is involved in each phase of the CAC and your team's role in it.
- Ensure that you take the time to do sufficient formative research to understand the socio-cultural and political contexts as well as how local people perceive and deal with health issues.
- Stay focused on the goal. A mobilizing goal should clearly state how people will benefit from their participation (e.g., improved health of all mothers). It should not be around specific actions or strategies.

Lessons Learned

- Share and celebrate successes!
- *"Never compromise that the organization supporting the groups is not giving anything physical to the groups. What you give is more strategic, psychological support…. It's even more valuable." (M. Rosato, MaiMwana, Malawi)*
- *"We've overcomplicated what is quite simple. All we're doing is helping women to identify problems and needs and solve them. We need to trust them. We are a catalyst. Can be an ongoing guide, but with a gentle footprint. Less involved, getting them to do more on their own." (M. Rosato, Malawi)*

Lessons Learned (cont'd.)

- It's all about recognizing and building individual, organizational and community capacity. Capacity must be considered in context and in relation to where you are now and where you want to go. Don't underestimate how important this is and disappear during the "Act Together" phase. Help communities assess their capacity, develop capacity strengthening plans to support their Action Plans and monitor their progress.
- Adequate preparation and training of program teams/facilitators is critical, especially as programs expand to larger scale. Training is more effective when it is highly experiential and broken into several workshops over the course of the first cycle rather than all done up front. Annual refresher training is also recommended after the first year.

Lessons Learned

- Anticipate and support the creation of links between individuals, groups, organizations and communities.
- Create the space for communities to develop their own strategies. During the planning phase, you may contribute information about strategies that are working in other places so that communities can make well-informed decisions. Don’t impose or “facipulate” plans. If communities are not coming up with potentially effective strategies, revisit the process you are using and revise it.

Lessons Learned

- Expect that the first year will be challenging and that there will likely be resistance among your own team, community members and possibly donors. Trust the process and stick to the principles. If you do, things are likely to turn around in incredible ways by the second or third year.

  "It was more work at first than we had expected. Everyone feels like it's now paying off. A lot of capacity building for the staff as well." (M. Rosato, MaiMwana Project, Malawi)

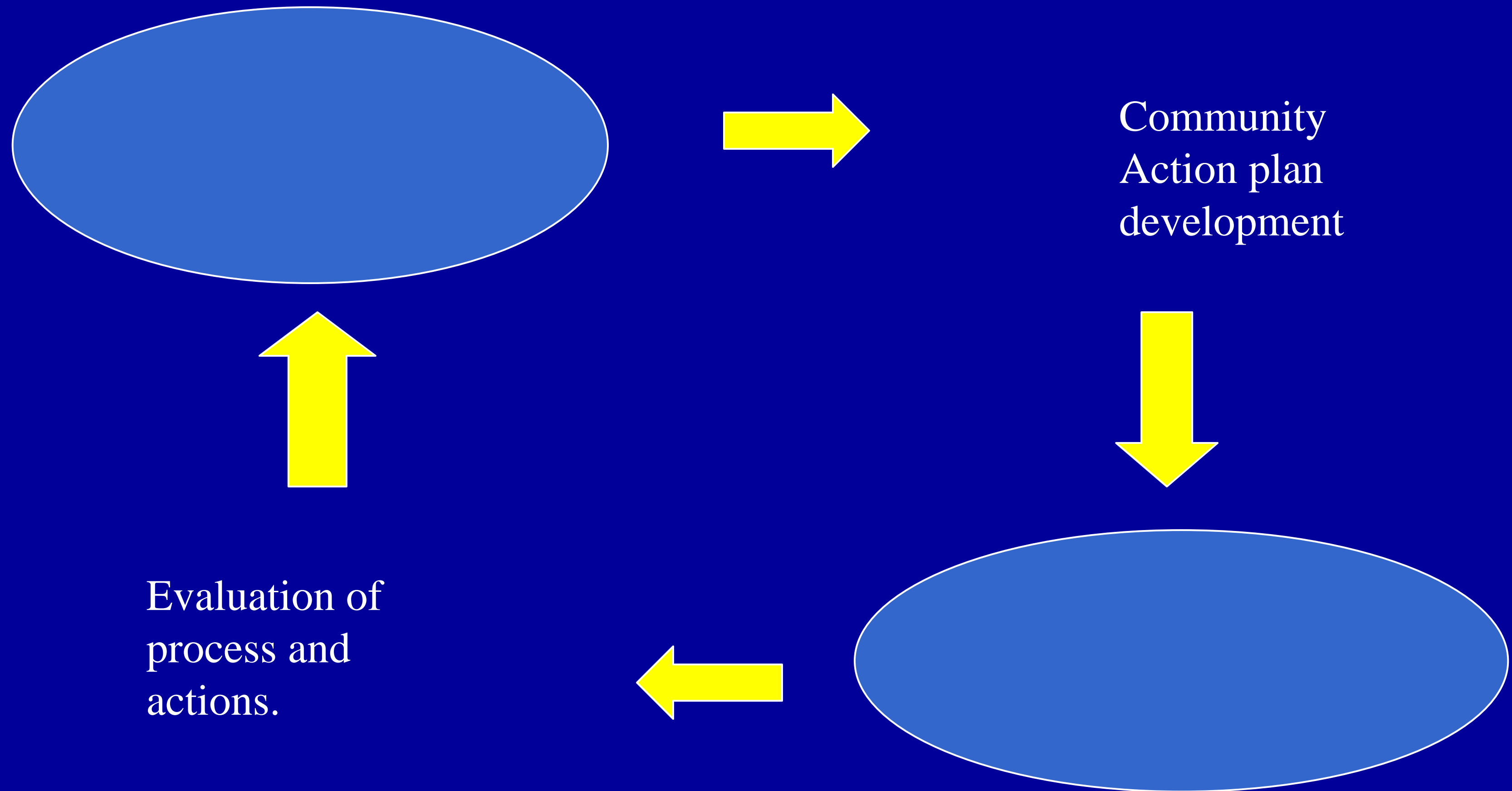
Current Challenges

- Competing priorities in health & development
- Scaling up challenges
  - Working in partnership
  - Measuring results in health outcomes & community capacity
  - Appropriate timelines
  - Appropriate funding levels (not too low, or too high)
- Increasing community voices in policy making
- Governments in transition
- Building communities in refugee and emergency relief settings

Challenges --continued

- Changing donor base; educating new donors
- Continued skepticism about effectiveness of approach & community members' ability to resolve their problems in spite of evidence to the contrary.
- Need to go back to programs where external assistance has ended to document what has happened.
- Organizations try to take short-cuts (to minimize time, effort)

Key Steps in Community Action Cycle



From USAID presentation: Community Mobilization Strategies for Increasing FP Demand and Sustainability: Basics of Community-Based Family Planning

What skills do "Mobilizers" need?

- Understand and be able to apply learning and behavior change principles and theories
- Be politically, culturally and gender sensitive
- Excellent communication skills-- LISTEN!
- Facilitation skills; know and use appropriate methods/techniques-- Don't "facipulate"
- Technical knowledge of heath issue
- Possess program design and management skills
- Organizational development skills (group dynamics, structures, etc.)
- Be able to assess, support and build community capacity/competency (organization, participation, leadership, management, link to external orgs, etc.)

NOTE: many programs have observed that facilitators who are most like the community people they will be working with, who are empathetic, and who have experience working with communities in the past perform the best, including community members (although often a little later in the program when they have gained more confidence).

What roles can external organizations play in community mobilization?

- **Mobilizer:** works directly with existing leaders and community groups to stimulate action.
- **Organizer:** forms new organizations or bring existing organizations together in new ways around an issue.
- **Coach:** helps community groups identify what they want to accomplish, and develop and implement strategies to get there.
- **Capacity Builder/Trainer:** to help communities strengthen specific capacities.
- **Liaison:** links communities with resources, builds networks.
- **Partner:** may work with local organizations to complement their efforts in a joint effort.
- **Advisor:** provides assistance to communities who request specific advice/technical expertise.
- **Advocate:** supports community members efforts to obtain resources or change policies.
- **Donor:** provides funding to community to address health issue
- **Marketer:** shares experience with others to expand CM

14 Keys to Scaling up Community Empowering Programs

1. Have a vision for scale from the beginning.
2. Choose pilot sites carefully.
3. Aim for high impact.
4. Develop solid partnerships with existing organizations at all levels.
5. Involve partners from other sectors. Fostering links between sectors favors an integrated approach.
6. Work with and foster the emergence and growth of dynamic community and political leaders.
7. Strengthen systems and organizational capacity.
8. Promote horizontal networking.
9. Test the approach.
10. Consolidate, define and refine.
11. Document with guides and tools.
12. Continuously monitor and evaluate.
13. Recognize achievement and publicize program results.
14. Diversify the funding base and encourage community ownership.

Taking Community Empowerment to Scale (Snetro-Plewman, et al, 2007, HCP).

Why Community Mobilization?

CM empowers communities to:

- actively participate in the evolving decentralization and democratization of civil society and government.
- build the social capital necessary for communities to work together successfully.
- respond to their diverse needs and problems, different cultures, beliefs and practices--one solution may not fit all.

Why Community Mobilization?

CM empowers communities to:

- leverage additional resources that may not be available to health system alone.
- apply political pressure to improve services.
- strengthen their capacity to address the underlying causes of health problems and reduce barriers to access of information and services.
- build mechanisms and systems to sustain health and other improvements.