

## Taking Community Empowerment to Scale



Lessons from Three Successful Experiences

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# Introduction

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

– Jonathan Mann

**[Empowerment is] a social action process by which individuals, communities and organizations gain mastery over their lives in the context of changing their social and political environment to improve health and quality of life.**

– Nina Wallerstein

The question of scale is often the first concern raised by donors and cooperating agencies when discussing the merits of community empowering approaches. Donors and cooperating agencies want to invest their limited resources in those projects with the greatest potential for widespread health improvement. While some may perceive community-based approaches—specifically empowering approaches—as intensive efforts that reach relatively small populations, successful widespread impact is possible. “Taking Community Empowerment to Scale: Lessons from Three Successful Experiences” describes three USAID-funded programs that used community empowering approaches to achieve public health impact at scale in three different settings—Africa, Asia, and the Middle East. It also identifies the success factors common to all three programs.

Each case study is a descriptive account of the program’s evolution, its stages, and the strategies used for successful scale-up. The brief review of current conceptualizations of empowerment and scale-up presented below illustrates the complexity of the issues at stake and sets the stage for the

presentation of the case studies. The analyses of the case studies, however, relied on interviews with program staff and existing documentation to unveil—inductively and with as few preconceptions as possible—the lessons learned. Comparing the findings from these inductive analyses with current theoretical frameworks was beyond the scope of this report. We encourage readers to use both existing theoretical frameworks as well as lessons learned from practice to refine the design of community empowerment programs at scale.

## What is Community Empowerment?

While the literature on community empowerment is vast and growing, for the purpose of this paper the definition of community empowerment is an approach whose ultimate aim is to strengthen the overall capacity of a community to address health and social issues beyond the life of a particular project.

Attributes of programs using empowerment strategies include the following:

- Addressing personal, interpersonal, and structural/political systems, simultaneously

- Fostering self-esteem and feelings of individual and collective efficacy
- Encouraging and enhancing critical consciousness and the ability to reflect on underlying assumptions affecting a person's actions
- Promoting equitable participation
- Increasing the ability of community leadership to facilitate the following processes within the community: conflict resolution, collection and analysis of data, problem-solving, program planning, resource mobilization, and policy advocacy (Goodman et al., 1998)
- Recognizing local/community authority to make and implement decisions (who has the power to make decisions or can confer authority for decision-making)
- Promoting community power and its ability to create or resist change, and turning decision-making power to local social actors
- Developing strong social and inter-organizational networks
- Recognizing community history, and social, economic, and political changes

## What is Scaling Up?

This report defines scaling up as expanding the impact of a successful community empowerment effort beyond a single or limited number of communities to the regional, national, or even multinational level (Howard-Grabman and Snetro, 2003, pp. 214-215). The term scaling up is used here to describe the amplification of an existing program in additional geographical sites or the application of a successful model in a new context and/or realm of activity.

## Scaling Up the Grassroots

There exists a wealth of literature on scaling up. The following theoretical frameworks on scaling up help illustrate the complexity of the issue. First, *Scaling Up the Grassroots* (Uvin) outlines the following four **dimensions** that can co-exist in the same project, although one or several of them may be predominant in a particular case:

1. **Quantitative scaling up** occurs when a program spreads to new target audiences, new geographic areas, or when a program approach is adopted by new organizations.
2. **Functional scaling up** occurs when a program addressing one technical area (e.g., health) expands into and is used in another area (e.g., agriculture).
3. **Political scaling up** occurs when an approach used at the community level broadens its reach through policy and other changes at the macro level and/or governmental institutions resulting in expansion to district, regional, or national levels.
4. **Organizational scaling up** occurs when a program diversifies or adds to its funding base or forms partnerships or strategic alliances with other organizations.

The case studies in this report illustrate how the above-mentioned dimensions co-exist. “Arab Women Speak Out,” for instance, expanded not only quantitatively (i.e., through new organizations and geographic locations), but also functionally (i.e., adapting the model for use in new areas such as literacy training), politically (i.e., garnering support from governments and international donors to facilitate scale-up), and organizationally (i.e., obtaining financial support from regional, national, and local organizations and groups to expand the initiative and ensure sustainability).

## How to Mobilize Communities for Health and Social Change

Howard-Grabman and Snetro (2003) define scaling up as expanding the impact of a successful community empowerment effort beyond a single or limited number of communities to the regional, national, or even multinational level. Their field guide, *How to Mobilize Communities for Health and Social Change*, describes five major ways programs are typically scaled up:

**Planned Expansion** – a steady process of expanding the number of sites for a particular program model once it has been pilot-tested and refined

**Explosion** – a sudden implementation of a large-scale program or intervention, without any cultivation of policy support or gradual organizational development prior to implementation

**Association** – an expansion of program size and coverage through common efforts and alliances among a network of organizations (Myers, 1992, p.379)

**Grafting** – the addition of a new young adult reproductive health program, for example, to an already existing program

**Diffusion** – the dissemination of materials so that other organizations learn about approaches and replicate them

The Madagascar case study presented in this report exemplifies the “planned expansion” of a program. From the start, it was designed with scale-up in mind. It started out in two pilot areas in view of reaching an important proportion of the country’s population over a relatively short period of time. Likewise, association—through the establishment of multi-sectoral and inter-agency partnerships—was one of the strategies used to achieve scale.

## Just and Lasting Change: When Communities Own Their Futures

In their book, *Just and Lasting Change: When Communities Own Their Futures*, Taylor-Ide and Taylor (2002) describe at least **four distinct scaling-up approaches**:

**The Blueprint Approach** refers to a fixed model which is replicated, such as construction projects. Not appropriate when site-specific modifications are required or when solutions need to be shaped by people’s voices.

**The Explosion Approach** provides rapid mobilization with a narrowly targeted intervention (e.g., emergency vaccination during an epidemic outbreak).

**The Additive Approach** focuses on adapting programs to local conditions, with local people using local resources. Good for when new models are needed (e.g., search for breakthroughs for child survival programming.) However, the projects using this approach often face long-term challenges because they are carefully and personally nurtured over time and cannot be sustained.

**The Biological Approach** explores and experiments with one population unit to find a mix of strategies suited to local conditions that work, and then provides an enabling environment for rapid growth and extension. Successful communities in one area develop the self-reliance and capacity to become regional training centers for neighboring communities. Exponential growth occurs in regional niches as the network of training centers expands to reach more communities.

Although all of these approaches play a role in development depending on particular needs, Taylor-Ide and Taylor point out that the biological approach has brought the most lasting benefit to communities and entire regions: “[This approach]...seeks solutions adapted to... [specific] realities, but also supports those solutions so that they expand rapidly.” The biological approach, they add, requires a shift from expert-driven solutions to

“an intentional enabling of community empowerment so that people can rise to their new opportunities” (p. 63).

The three cases presented in this report are reminiscent of the biological approach. In the Philippines, for instance, community “learning schools” were established at the grassroots level to facilitate scale-up. Organized exchange visits strengthened cooperation and networking across communities while at the same time broadening the geographical areas covered by the program.

Experience over the last decade has shown that community empowerment can be scaled up. The challenge is to scale up without diminishing the quality of the original community empowerment effort (Howard-Grabman and Snetro, 2003, p. 214). This report identifies 14 success factors that program managers may find useful to support the scale-up of empowering community-based efforts. It also highlights the “pathways” and strategies that led to successful scale-up in three case studies. The strategies described in this report have been previously documented, but reviewing and analyzing them in the framework of specific programs can help readers understand, refine, and support their own efforts and the efforts of the communities to scale up empowering health initiatives.



# LESSONS LEARNED

## Key Factors for Successful Scale-up

This synthesis identifies fourteen factors as key to successful scale-up from the three case studies detailed later in this report. The list of scaling-up best practices is the result of analysis and comparison of project-related data gathered from interviews with program managers and support staff, and a review of project documents and materials. Donors and cooperating agencies (CAs) can refer to this list when designing community empowerment programs they hope to take to scale.

- 1** *Have a vision for scale from the beginning.* The time to think about and plan for scaling up is not after piloting a program which proves to be successful, but during its conception and design. It is much easier to go to scale when a program already contains the key components, rather than adding them later.
- 2** *Choose pilot sites carefully.* Choose sites that have some positive aspects, such as dynamic leaders, existing community groups, volunteers, and potential for high impact.
- 3** *Aim for high impact.* Results build momentum and support for scaling up. Program results that are easy to measure and easy to see get attention and create excitement. With community empowerment programs in particular, it is important to focus the community's initial efforts so that they gain confidence and skills. This increases the chances that the program will succeed, especially at scale. Early success not only builds confidence, especially among marginalized groups, but attracts more interest and support.
- 4** *Develop solid partnerships with existing organizations at all levels.* The sooner a community-based initiative establishes contacts and builds links at multiple levels, the easier scale will be achieved. Working with existing local groups, NGOs, private sector groups as well as district, regional, and national government units establishes relationships with partners whose support will be essential when it is time to expand.
- 5** *Involve partners from other sectors. Fostering links between sectors favors an integrated approach.* If the program has a health focus, for example, try to involve partners from the agriculture or education sector. The broader your base the more support and opportunities there are when it is time to expand.
- 6** *Work with and foster the emergence and growth of dynamic community and political leaders.* When it comes time to scale up, “champions” can act as the public face of the program and advocate for it at all levels. These spokespersons should be well-respected and well-spoken.

- 7** *Strengthen systems and organizational capacity.* Scaling up will stretch the technical and organizational skills of partnering groups and organizations. Assessing and supporting partners' capacity ensures that human, management, and financial resources can cope with program expansion. By strengthening organizational capacities such as good leadership, financial accountability, human resource management, strategic planning, and monitoring and evaluation systems, organizations will be more able to effectively manage initiatives going to scale. Building skills at multiple levels also ensures quality—such as when a core group of qualified master trainers effectively builds the capacity of peers at regional, district and community levels.
- 8** *Promote horizontal networking.* Community-to-community learning exchange facilitates an exponential growth of empowering grassroots initiatives and helps consolidate networks for effective bottom-up advocacy. Horizontal networking helps foster solidarity at the local level and strengthens social cohesion. It also encourages communities to continue learning from their own experience and that of other partners.
- 9** *Test the approach.* Proving the effectiveness or impact of an intervention is essential before taking it to scale. Assessing impact or finding out what is and is not working is accomplished through carefully evaluated and documented research. Redesign the program as necessary before going to scale. The sooner the program can demonstrate effectiveness, the more success it achieves, and the more momentum the program will develop for scaling up.
- 10** *Consolidate, define and refine.* In preparation of going to scale it is best to identify the essential empowering program components needed to achieve impact, while at the same time remaining flexible and allowing for local adaptations. Planners should know what components of the original program to hold onto—and advocate for—and which ones to let go. Simplify program design as much as possible. Written documents should be accessible in user-friendly language.
- 11** *Document with guides and tools.* Program materials, such as forms, toolkits, manuals, training modules, brochures, and guidelines, greatly facilitate ease of learning and uptake by others. In the beginning, and as the initiative moves to scale, take notes, keep records, document your procedures and processes, and keep copies of all the materials produced. As the program moves beyond the original settings, keep a comprehensive record of what was done at each stage and how it was done. This kind of how-to manual will help others at successive levels of scale follow the approach more easily.
- 12** *Continuously monitor and evaluate.* As you go to scale, keep a very close watch on how the program is working at the expanded locations—through frequent monitoring, evaluation, site visits, interviews—and make changes as necessary before expanding further. It usually takes several iterations to get the basics right. Remember: donors and partners—including those at the community level—need data. Collect good records on program inputs and outputs, and share these results.

- 13** *Recognize achievement and publicize program results.* At the beginning, and as you expand, people at all levels need to know about the program. Use the media and other contacts, especially partner organizations, to get the word out. Distribute reports and evaluations, and invite NGOs, journalists, and government officials from all levels to come in and see the program at work. It is also important that communities continue to monitor their own progress so they can be recognized for and inspired by their hard work and success.
- 14** *Diversify the funding base and encourage community ownership.* The broader the program's funding base, the more potential sources of support there will be as the program expands. Also, local resource commitment to the project often translates into financial and in-kind contributions from community and other local organizations, which in turn fosters greater community ownership and sustainability as the project expands.



# Overview of Strategies for Scaling Up from Three Case Studies

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The 14 success factors outlined in the previous section derive from an analysis of three case studies of health-related community empowerment programs that operated at scale. These case studies were chosen because they:

- Embody key components of community empowerment approaches
- Represent the work of several different agencies and organizations in diverse geographic settings
- Demonstrate positive individual behavioral outcomes as well as increased community capacity

This section presents overviews of the successful scaling-up strategies employed in the three programs. A page reference for the complete case study appears at the end of each summary.

## Empowered Communities Improve Their Health and Preserve Their Environment in the Philippines

*Coming to scale was intrinsic to the Appreciative Community Mobilization approach. We looked for provinces that could serve as models and leaders who could champion family planning and community empowerment strategies.* – Naida Pasion

**The teams in the Philippines used the following strategies for achieving scale, which can serve as a guide for others seeking empowering and effective program design at scale.**

### Pilot-testing the approach in carefully selected areas

- Criteria for site selection of the pilot Appreciative Community Mobilization (ACM) included not only need, but also the presence of leadership that could champion the approach.

- Pilot project sites in 16 districts with KSP (*Kalusugan sa Pamilya*) and four with PESCO-Dev (People and Environment Co-Existence Development) established efficacy of methods, allowed for approach refinement, and helped in developing easy-to-use tools, such as an ACM manual and orientation guide.
- Testing a minimum package of inputs allowed for rapid expansion. These inputs included well-motivated health service providers, active municipal leadership, committed family-planning volunteers, and supportive village leadership.

### Partnering for sustained action and advocacy

- The ability of both projects to sustain collective action over a large geographical population was in large part due to their ability to establish sound partnerships from the start with existing government, NGO, and political institutions. The projects in coordination with these partners also made strategic plans for scale-up.
- The Philippines team fostered dynamic political and institutional leaders who have continued to be “champions” of ACM even after the program came to an end. For example, the mayor of Concepcion is now a technical advisor for Management Sciences for Health, which covers 750 municipalities with its

application of ACM in the LEAD multi-health project. He is also on the national advisory group for the initiative.

- Advocacy was important at all levels. For example, PESCO-Dev advocated population, health, and environmental (PHE) action using the ACM approach by playing a role in setting agendas and policy formation at the local, municipal, and national levels. One way was to create local *barangay* and municipal Fisheries and Aquatic Resources Management Councils (FARMCs) whereby local government units work jointly with community members to promote the project's objectives. At the national level, Save the Children (Save) helped create and strengthen a national PHE coalition. For example, Save helped mobilize local leaders considered PHE champions to bring this agenda to their peers. As a result, local and national leaders met at the first national PHE conference in November 2004 where they affirmed their commitment for the mainstreaming of the PHE agenda.

#### **Garnering support and facilitating action at different levels**

- National- and provincial-level action fostered policy and funding support for country-wide expansion. The creation of a national-level PHE coalition and “advocacy networks” linked ACM efforts and raised policymakers’ awareness of the approach at a critical time in family planning policy formation.
- The projects linked community, municipal, and national implementing partners to diverse national and international funding sources.

#### **Focusing on local capacity strengthening while strategizing geographic expansion**

- KSP and PESCO-Dev achieved scale-up, in part, by using strategies focused on geographical expansion, including developing a large cadre of community

family-planning trainers at the grassroots level and working directly with pilot communities with plans to expand to neighboring communities.

- The projects also worked with a large number of ACM family planning volunteers who were selected from existing pools of community volunteers from the *barangay* health worker training structure. Fourteen-member ACM teams at the village level developed project proposals for funding from municipal governments.

#### **Fostering horizontal learning and cross-sectoral networking**

- Model “learning schools” established at the grassroots level helped share approaches among communities. Structured exchange visits between communities harnessed the richness of community learning and demonstrated the practical applications of empowering processes.
- Regional ACM training teams supported action at the neighborhood and village levels. Teams consisted of a cross-sectoral mix of local government units, including the mayor’s office, agricultural and health departments, and community representatives.

#### **Facilitating participatory monitoring and evaluation**

- Partners collaboratively decided on indicators of success (health outcomes and community capacity). Monitoring the efficacy of the ACM approach and making adjustments were key to developing an appropriate model at scale.
- Partners shared evaluation and feedback of impact early on with the wider community, government, and political officials, thus fostering local ownership while at the same time building political and donor support.

**See page 1 for complete case study.**

# Arab Women Speak Out (AWSO)

The following strategies used by AWSO project partners contributed to successful scale-up in various ways.

## Careful development of approaches and tools

- A carefully designed, comprehensive, and ready-to-use package, including an easy-to-use video tool, reached large numbers with personal stories. The video was used in synergy with facilitated dialogue.
- The development phase lasted three years, working in multiple places simultaneously to test approaches in different contexts, and expanded from there.

## Partnering for locally adapted and sustainable action

- The AWSO team identified key partner organizations and developed strong partnerships. Local partners made a commitment to invest their own time and resources in the initiative from the start.
- Because AWSO was implemented through governmental agencies, NGOs, and international organizations, the potential for scale increased as each organization could use and expand the model in a variety of ways.

## Adopting a preventive and holistic approach to health (focused on psychological well-being rather than on absence of disease)

- A holistic approach to health allowed for cross-cutting application. Agencies were able to integrate the training into ongoing programs, in areas such as health, micro-enterprise, literacy, and environmental protection.

## Achieving capacity building at scale through the training of master trainers

- National-level trainers trained cadres of trainers chosen by local NGOs, resulting in an effective training model at scale.

## Keeping flexible and encouraging local decision-making

- Flexibility with the video package was a core component of the program. In addition, local agencies retained major decision-making in how to plan and facilitate sessions at their sites (e.g., recommend facilitators, prioritize content, choose venues, arrange transport), which facilitated implementation.

## Reaching people where they are

- Implementation of AWSO began at central community venues such as health centers, social development centers, and beauty parlors—a strategy that eased the logistics of operations and attracted large numbers of people over time.

## Documenting and sharing findings to refine strategies

- The AWSO team continually documented the program's activities and conducted an impact evaluation in four countries three years after the project's implementation, which guided further scale-up strategies.
- Coordinating organizations shared materials and findings of the project with all those who shaped planning at scale.

See page 7 for complete case study.





# The Madagascar Child Survival and Reproductive Health Program

*Program processes, namely the community and communication components, were designed to prioritize the needs and realities of the target population. The program achieved large-scale success in a short time frame, with adequate resources and flexible approaches managers could apply and adapt across a range of settings.*

*- BASICS II, 2004a*

**From the start, this project had scale-up in mind. The Madagascar team considered the following strategies key to effective scale-up.**

## **Pilot-testing the approach to ensure a strong foundation**

- The project started in only two districts. This strong foundation built support and know-how for expansion.

## **Favoring interagency and multi-sectoral partnerships**

- Interagency partnerships jointly set priorities. All agreed to use the same communication messages and materials so scale could be achieved.
- Although the project's technical focus was health, having partners in other sectors (e.g., education, women's groups) allowed the project to achieve scale.

## **Working from the district level while at the same time assuring central government's support**

- National and international technical advisors advocated to help ensure in-country collaboration and acceptance—which opened doors for scale-up.

## **Strengthening institutional and community capacity**

- The project aimed to strengthen systems and institutional capacity among governmental and non-governmental partners, a strategy that facilitated improved quality of, and access to, health services. It also bolstered program recognition and acceptance.
- The program mobilized massive numbers of volunteers chosen by their own local groups and trained by skilled trainers cultivated at the district level. The volunteers worked within their community group's own structures, which handled logistics to allow for replication of training on a large scale.

## **Phasing in interventions**

- The program team phased in technical interventions to avoid overloading the system or staff. This increased adaptability of the program as it grew in new and different settings.

## **Establishing key core project components while allowing flexibility**

- Continuity in key project components led to visible results, while flexibility was used to respond to the changes and challenges that inevitably occur as a project scales up over time.

## **Monitoring progress to design and set targets for scale-up**

- From the start, careful monitoring was a priority; it allowed for scale-up in several ways. For example, insights from pilot sites combined with analysis of local situations influenced program design. Attainable

targets were set for geographic expansion based on what was accomplished previously.

### **Diversifying funding**

- Local institutions managed and used supplemental grant funding, which allowed for scale-up beyond the period of intensive activity.
- The project made sure to draw combined funding from national and international sources at a level adequate for rapid expansion.

**See page 11 for complete case study.**

# Case Study I



## Empowered Communities Improve Their Health and Preserve Their Environment in the Philippines

In the Philippines, several related projects used a successful approach known as Appreciative Community Mobilization (ACM) to go to scale to effect change in family planning, child survival, and environmental conservation. ACM is a hybrid methodology combining two approaches: community mobilization (CM) and appreciative inquiry (AI). Community mobilization is a capacity-building process through which community individuals, groups, or organizations plan, carry out, monitor, 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 (Howard-Grabman, 2003, p. 3). Developed by David Cooperrider and Suresh Srivastva at Case Western Reserve University, Appreciative Inquiry is a process that builds on an organization's (or community's)

positive strengths, values, successful moments, achievements, best practices, and resources to bring about positive change.

The *Kalusugan sa Pamilya* (KSP or Family Health) project originally received funding from USAID through a grant to the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP) through the Population Communication Services (PCS) program. Under the PCS project, Save the Children/US began KSP and received support from several Philippine partners, including local government units (LGUs), municipalities, the Alliance of Coastal Municipalities for Health and Development (ANIHEAD), the Local Enhancement for Development and Health (LEAD) project, and the Enhanced and Rapid Improvement for Community Health (EnRich) project.

The following describes how the program achieved health and development outcomes and maintained empowering approaches through community participation and management.

## Initial Project Scope and Development

### SUCCESS FACTOR

#### *Involve Partners from Other Sectors*

In the Philippines, the ACM approach initially focused on the health sector, but then expanded to the environmental conservation sector. ACM went on to include the school-health and education sectors.

KSP began in mid-1997 in partnership with LGUs in Iloilo Province and Iloilo City. The project piloted an approach to boost utilization of family planning and child

health services using ACM as a main strategy. The underlying assumption was that positioning family planning as a contributor to child survival would increase demand for both services. The project sought to identify the most marginalized families in the community through the community members themselves. These families belonged to the lowest 30-percent income bracket in the community and most likely did not own their home or the land they tilled. Furthermore, they likely did not access services at health centers and were not active participants in village decision-making. The pilot project began in 16 municipalities and reached a total of 30,400 individuals. By the project's end in 2002 coverage reached a population of 65,000 in 22 municipalities primarily through expansion in the *barangays* (villages).

The project expanded and evolved into the People and Environment Co-Existence Development project (PESCO-Dev), which linked population growth, family planning, and environmental concerns. The staff piloted the approach in four municipalities in 1999 and later expanded it to 14. The project continued to expand under ANIHEAD with support from UNFPA and the

Table 1: Timeline for Scaling Up

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

Philippine Canadian International Development Fund. With the USAID-supported EnRich initiative, the ACM approach helped to increase contraceptive prevalence, utilization of family planning, maternal and child health services, and tuberculosis control services among hard-to-reach populations. In 2004, LEAD used ACM at the national level. Funded by USAID and primed by Management Sciences for Health, LEAD focused on innovative service improvement strategies and systems strengthening to improve delivery and financing of family planning, TB treatment, HIV/AIDS surveillance, and Vitamin A and MCH services.

Table 1 illustrates the timeline by which the ACM approach was used to scale up projects through strategic partnerships.

## Pathways to Success

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*The KSP project definitely had as one of its stated objectives to build community capacity as well as achieve the family planning outcomes.*

*Naida Pasion, KSP Project Coordinator*

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### Communities Discovering, Dreaming, Designing, and Delivering: The 4-D Cycle

The Philippines experience suggests that programs can encourage and bolster genuine participation by creating a framework through which communities can organize themselves, explore health issues, and then plan, implement, monitor, and evaluate their own projects. ACM built on the capacity of people to be innovative despite limited resources and other constraints. The “4-D” cycle used in ACM allowed communities to go through a process to identify their strengths and assets (**D**iscover), articulate their desires and aspirations (**D**ream), develop their short-term objectives (**D**esign), and define immediate steps for action (**D**elivery). Through

representative leaders, communities defined their goals and objectives, which helped develop a sense of ownership of the program. They quickly became aware of the benefits the project could provide for their children, family, and community. This participatory process also brought with it an important benefit to community members—the confidence in their ability to do something about their situation.

## Participation of the Most Marginalized

### SUCCESS FACTOR

#### *Choose Pilot Sites Carefully*

In the Philippines, the early identification of key district partners allowed communities to create a common vision and plan for scale, including developing common indicators for measuring success.

The aim of this approach was to reach the most marginalized families in the community, as identified by community members. Once identified, community members designed plans to ensure the participation of these “priority groups” in decision-making. As a result, representatives from marginalized groups assumed positions in formal community structures and took on roles as advocates for the utilization of child health and family planning services.

### Building on Social and Inter-Organizational Networks

The Philippines team assessed how communities were organized and worked with existing community systems including health volunteers, local NGOs and networks to create a foundation for going to scale. Project staff helped organize village ACM Teams, drawing from existing community structures, including local leaders (formal and informal), community health workers, local government

committees, and Department of Health facility staff. The teams were linked into local Barangay Development Councils. To engender fuller community participation, ACM Teams also invited neighborhood or *sitio* (small neighborhood) representatives from marginalized groups to join the teams. By working at multiple levels, the ACM Teams made strategic alliances which encouraged government systems to reach out and grassroots groups to link up. Linking communities to outside bodies was crucial to garner support and obtain the necessary resources to fund local initiatives. For instance, communities developed and submitted proposals to municipalities and organizations, which resulted in increased health and environment funding and policy support.

## Sustaining Change through Local Capacity-Building

The Philippines team recognized early on the need to develop non-health related skills. Community and institutional partners received training in the ACM “4-D” process. Leaders and teams used their expertise to train new municipalities and mentor other leaders. Other skills that were vital to the process included leadership, conflict resolution, group management, proposal development, human and financial resource mobilization, and advocacy for policy change.

## Family Planning Action Sessions

The Philippines team produced Family Planning Action Guides to build the volunteer trainers’ capacity to carry out couples counseling for family planning. Participatory exercises and step-by-step instructions included colorful picture cards, testimonials from successful couples, and a Family Planning Action Card for couples to complete. A distinct feature of these sessions for PESCO-Dev was discussing links between population growth, coastal ecology, and reproductive health choices.

## SUCCESS FACTOR

### *Work with Dynamic Community and Political Leaders*

In the Philippines, “champions” for the ACM approach fostered leadership. Program managers selected sites with dynamic leaders that advocated for the ACM approach. Leaders included a dynamic mayor with a good development orientation, a family planning advocate, and an influential community member with influence over other municipalities and other provinces. Selecting impoverished areas with dynamic leadership—not necessarily formal leadership—supported emerging ACM leaders.

## Using Complementary Communication Media

Beside the ACM approach, project managers recognized the power of complementary mass media approaches for creating a political and social environment for change. Strategic signage and radio campaigns promoted the slogan “If you love them, plan for them,” thus positioning family planning as a child-focused decision.

## Linking, Learning, and Celebrating

Community-to-community exchange visits helped share strategies and lessons learned across communities. After communities finished one cycle of the 4-Ds, an additional fifth ‘D’ for “Dancing and Drumming” allowed communities to share experiences, celebrate successes, and forge communication channels between communities.

## Communities Measuring Change

Community-level monitoring of health and environmental outcomes, community participation, and capacity was a key component of the approach's success. For instance, family planning volunteers used tally sheets to keep track of the number of couples seen and those who had adopted contraceptive methods. Local ACM Teams compiled information and shared it with the community at large during periodic meetings, and then sent it up the system to program staff. Encouraging the dissemination of project impact to the community generated excitement for continued action.

### SUCCESS FACTOR

#### *Strengthen Systems and Organizational Capacity*

In the Philippines, ensuring that communities and other partners had the capacity to continuously innovate and spearhead activities was key to building empowered communities. KSP and PESCO-Dev implemented a variety of capacity-building interventions on ACM approaches and processes, including both formal training and mentoring approaches. Government and NGO staff, political leaders and community members took part in these interventions and ultimately became trainers themselves. Community groups developed their capacity to implement, monitor and evaluate their own project efforts. Other community and partner capacity-building efforts included leadership mentoring, training on proposal development, advocacy for policy change, and data collection and analysis.

Applying the ACM approach to family planning and environment efforts in the Philippines proved effective both in terms of individual health outcomes and increased community capacity to manage and sustain these outcomes. Individual- and community-health improvements achieved included the following:

#### *Individual/Family Outcomes*

##### *KSP*

- The use of many maternal health services significantly increased from baseline in both urban and rural populations, including pre-/postnatal exams, iron supplementation, tetanus toxoid immunization, family planning and health education, and vitamin A.
- BCG, DPT, OPV, and measles immunizations steadily increased for marginalized rural groups.
- Appropriate treatment of diarrheal disease was significantly higher at the endline for rural marginalized populations (SAVE, 2002a, pp. 3-6).

##### *PESCO-Dev*

- Contraceptive prevalence rates in project sites increased by 7 percentage points compared to 4 points in the region (SAVE, 2004, p. 2).
- Municipalities that participated in the program established 18 marine-protected areas providing 903 hectares of fish sanctuary.
- Overall, communities that participated in integrated population, health, and environmental (PHE) efforts demonstrated higher levels of contraceptive use, FP service utilization, and improved coastal resource management practices.

Researchers not only measured project outcomes in terms of impact on maternal and child health, but also on the capacity of participating communities to identify their health needs and organize for collective action.

Demonstrated increases in community capacity included the following:

### Community Outcomes

#### ***KSP***

- All communities developed action plans and completed 92% of them on time.
- Of the 232 KSP team members trained, almost two out of three members came from the *sitios* where they represented a majority of marginalized groups. Many assumed leadership positions.

#### ***PESCO-Dev***

- LGUs located in municipalities passed 87 PHE resolutions, leading to the formation of PHE technical working groups, standards for reproductive health facilities, and LGU budget allocations of approximately \$62,000 for PHE (Pasion & Mendoza, 2002, p.28).
- A national-level PHE coalition formed, with a total organizational membership of 200 local and international NGOs (Pasion & Mendoza, 2002, p.3).
- The first national PHE conference took place in 2004, at which local and national leaders effectively advocated for mainstreaming the PHE agenda into national environment and health policies.



# Case Study II



## Arab Women Speak Out

Arab Women Speak Out (AWSO)—designed by CCP in collaboration with the Center of Arab Women for Training and Research (CAWTR), with support from the U.S. Agency for International Development—seeks to empower women throughout the Arab world to achieve their potential inside as well as outside the home. The project was developed in five countries—Egypt, Tunisia, Palestine, Lebanon, and Yemen—from 1994 to 1998. NGOs in 10 Arab countries began to implement the program in 1999. From its inception, this project set both community- and individual-level goals and sought to evaluate change on both these levels. AWSO's community-level goals were to

- Provide role models of achievement and self-esteem for Arab women, while countering negative images that prevail in the media
- Expand women's awareness of diverse life options

- Inspire women to take action within their community in such areas as economic development, governance, literacy, and community health
- Encourage the acceptance of these roles within communities by men and women, opinion leaders, religious groups, policymakers, and national organizations

Specific objectives at the level of the individual woman included the following:

- Increased self-confidence, self-image, and self-efficacy
- Increased participation in decision-making at the household and community levels
- Improved reproductive health practices

## Project Development and Reach

A central component of AWSO is a series of video profiles of Arab women who overcame gender barriers and reached self-determined goals. Grassroots organizations helped identify the women portrayed in the video to ensure that their profiles were diverse, real, and could translate across borders. The AWSO approach helped create a project with the power, relevance, and adaptability to work long-term and on a large scale.

Participants watch these profiles during a facilitated training that helps them consider what resources and strategies they could use to attain their goals. AWSO is “based on the principle that the solutions to problems—and ultimately change—come from within a community. Most people need an experience, an encounter, or an introduction to new ways of thinking before they can initiate change” (Jabre, 2003). To bring about lasting change from within, and on a large scale, the project developed the following set of complementary tools:

- Case study publication: Profiles of Self-Empowerment
- Ten 20-minute videos: Portraits of Self-Empowerment (in Arabic only)
- A training manual comprised of eight modules, *Training for Self-Empowerment*
- A 60-minute composite video that includes highlights from the ten video portraits (with English sub-titles)
- A tool for the critical analysis of images of women in the media
- A 15-minute advocacy video (in English)

From its inception, the AWSO team intended the program to be large-scale in several countries, achieving quantitative and functional scale-up over a ten-year period (Jabre, 2005). In 1994, the team developed a conceptual framework and identified key regional partner organizations. Over the next two years, they worked with social researchers in five countries, prepared and

implemented field research for the development of the case studies, completed initial filming and editing, and developed informational material. In 1997, the team developed a draft training manual and video guide and completed the analysis of the case studies. Furthermore, they developed a full composite video, finalized training materials and media tools, printed “AWSO: Profiles of Self Empowerment,” and packaged the entire kit, which was disseminated at the end of 1998.

### SUCCESS FACTOR

#### *Stay Flexible*

The AWSO project developed a series of complementary materials that enabled facilitators to tailor their training sessions for the community. Facilitators chose the video portraits they would show in the sessions and they learned how to best guide dialogue using the AWSO training manual.

In 1999, NGOs and government ministries implemented the first AWSO field trainings in Yemen, Lebanon, Tunisia, Algeria, Egypt, Palestine, and Jordan. Off-shoot projects in Egypt and Jordan developed additional training series, such as “Women Empowerment for Reproductive Health.”

In 2000, CCP conducted AWSO’s first impact evaluation in three countries, using a control group comparison to explore the impact of the project on self and family (Underwood & Jabre, 2001). Women exposed to the project were more likely than those not exposed to

- Know where to find information regarding loans, health, and community participation
- Believe they could make a difference in community affairs
- Report playing more active roles in decision-making about such issues as their children's education (79% vs. 59% for sons; 71% vs. 49% for daughters)

- Start a new business venture (30% vs. 18%), participate in community efforts to improve health care (51% vs. 40%), talk with other women regarding negotiation skills (53% vs. 37%), and participate in community meetings (58% vs. 40%) (Underwood & Jabre, 2001)

## SUCCESS FACTOR

### *Document with Guides and Tools*

The initial development of a powerful and moving interactive video, as well as complementary materials such as a facilitation manual, allowed thousands of women wide access to empowering life stories leading to personal and community change. These materials not only facilitated scale-up in other communities but also could be used with potential donors and partners.

The evaluation also suggests that the project had a considerable positive impact on the organizational structure and stature of local NGOs. “They observed improved institutional and personnel capacity, greater credibility for NGOs within communities, and among donor agencies, an enhanced advocacy role in the promotion of women’s rights, and an increased ability to secure funding for local activities” (Underwood & Jabre, 2001, p.2).

AWSO’s reach over time provides a sense of the scale one might expect through a collaborative effort of this type.

- December 1998, **31** people, in ten countries, gained certification as national AWSO master trainers.
- By 2000, more than **60,000** community women had participated in the training sessions.
- By 2002, **25 national NGOs and government agencies** had used AWSO in seven Arab countries—Egypt, Jordan, Lebanon, Palestine, Tunisia, Algeria,

and Yemen. AWSO had reached some **150,000** women.

- By 2004, AWSO had reached more than **500,000** women in 10 Arab countries.

The following are just a few examples of how AWSO has recently achieved scale-up (Jabre, 2003).

- In Egypt, Save the Children USA developed a plan for the implementation of AWSO in four governorates, and Caritas adapted AWSO for literacy training.
- CAWTAR/Tunis submitted a proposal for AWSO on the regional level.
- Ajjaluna/Lebanon received funding to use AWSO for rural development in two regions.
- Mouvement Sociale implemented community development interventions based on AWSO in Lebanon.

AWSO has also seen a few major adaptations of its work in and beyond the Arab region:

- “Women Empowerment for Reproductive Health” is a new series in Jordan and Egypt that guides discussion into such areas as women’s lifecycle health care with a focus on prenatal, safe delivery, and postnatal care; FGM and domestic violence; the role of the husband in safeguarding woman’s health; peri-marital health; pre-marital counseling; and, care during pregnancy and post-delivery. Some initial findings suggest positive impact. In Jordan, a referral system to RH services began operating in Ajloun and 12% of women benefiting from the training sought services for the first time right after the sessions (Jabre, 2003).
- The “African Transformation” project adapted AWSO to the African context and envisions “a tolerant society in which men and women mutually respect each other, critically examine and change gender-based inequities, and participate in equitable decision-making and resource allocation.” It focuses on HIV/AIDS prevention among other health issues (CCP, 2004).

## Pathways to Success

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*I was afraid to participate. I always felt that I can't be a productive person. After the training I felt something growing inside me. I became more eager to try working in my community.*

– Project trainer, Jordan

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### Work Inside Out and Outside In

According to “Social Learning Theory,” originally developed by psychologist Albert Bandura (Bandura, 1977), people learn new behaviors and identify their own strengths by seeing those capabilities modeled by others. AWSO worked simultaneously at the level of the individual (inside out) and of the international Arab community (outside in). Through video, project participants identified role models, and through structured dialogue, they examined the context of their lives (Jabre et al., 1997).

### Link Individual and Collective Empowerment

“Empowerment Education” is a theoretical approach credited to Brazilian educator Paulo Freire that contends that knowledge and action emerge not from experts but from group dialogue at the grassroots level. It is through reflection and action, born from dialogue, that individuals and communities develop their capacity to transform their own reality. Although individual empowerment is not the same as community empowerment, empowered individuals often function better in groups and contribute more to empowered communities. AWSO intentionally portrays women with personal empowerment that goes beyond traditional roles. The project depicts these women living in the mainstream and active within their community. This allows for broader impact—well beyond the individual.

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*In this effort, zero-sum is not the goal—it need not be.*

*Autonomy and independence are not the goal.*

*Interdependence is key. If we have two or more responsible adults in a family, you strengthen the family. The women saw themselves as part of a larger whole and didn't want to undermine that. They wanted to strengthen their own capacities in a way that is consonant with their context—not separate from it.*

- Carol Underwood, Senior Research Officer, CCP

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### Bolster Health through Empowerment

AWSO partners recognized strong links between a woman's individual capacities, her connection to other women, and her health. In so doing, they expanded the potential for sustained health improvements across large numbers of women.

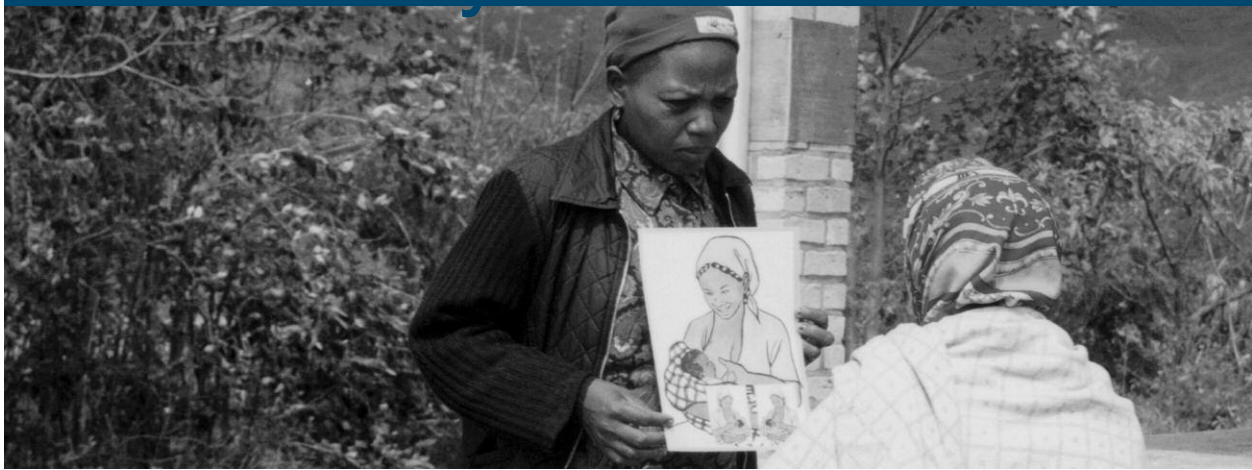
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*Before addressing health directly, we must address self-confidence and self-respect; her health must be important to her—first and foremost. I think the link between the self respect and the skills in decision-making are the most direct ones. If she sees herself as a human being who deserves the attention, she will seek health care. I (also) think that building up the female solidarity is very beneficial—because the members of the group keep connected even after the session is finished. Usually, women will dismiss a health problem but, in the group, they talk about it and realize they aren't the only one who has it—“I'm not alone”—and then often go to the clinic together.*

- Bushra Jabre, Near East Regional Officer and Communication Advisor, CCP

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# Case Study III



## The Madagascar Child Survival and Reproductive Health Program

BASICS II is a global child survival project supported by USAID. One of its programs, the Madagascar Child Survival and Reproductive Health Program, demonstrates how a participatory project with a positive and visible impact in the community can build empowerment within the community and go to scale. Under BASICS II, the Madagascar Ministry of Health implemented this integrated health program from 1992 to 2002 with the support of several partners, including the LINKAGES Project, Jereo Salama Isika, Advance Africa, UNICEF, and The World Bank. This case study focuses specifically on how the project's community and communication components led to community-based work on a large scale.

### Project Development and Expansion

#### Phase I: Two Districts (1996 – 1998)

This project's design had several goals in mind: to focus on communities; to provide a package of services (including vaccination, child health and nutrition, and family planning); and to scale up rapidly. BASICS pilot tested the project in two districts within two of Madagascar's most populated provinces (BASICS II, 2004a). The evaluation included two surveys conducted in a number of communes in each district, one in 1996 at the start of the project and one in 1998 (BASICS II, 2004a). The surveys documented the following notable health improvements and community effects:

- The percentage of children 12–23 months of age who were fully immunized increased from 57% to 78%.
- The percentage of women who began breastfeeding immediately after delivery increased from 21% to 69%.

- Cases of sick children whose parents received at least two correct messages from the health care provider on when to bring the child to the health center increased from 3% to 51%.
- The number of “active” health committees engaged in promoting key messages increased from 40 in 1997 to 146 in the eight program communes in 1998.
- The number of community members reached through meetings and workshops increased from 850 in 1997 to 2,089 in 1998.

A report on the pilot phase stated that while no “conclusive evidence” proved these changes were attributed solely to the project, “the fact that national and province-wide indicators remained low or at 1996 levels, while in 1998 these levels were higher [in the two pilot districts], and the fact that processes such as health provider skills and community actions improved, are indications of a program effect” (BASICS I, 1999, p.29).

## SUCCESS FACTOR

### *Aim for High Impact*

In Madagascar, the project developed a package of achievable goals with community prioritization and buy-in. By establishing a starting point and a finish line with do-able activities, communities witnessed results and were motivated to sustain active participation and augment their efforts.

## Phase II: Scaling Up to Nearly Half the National Population (1998 – 2002):

The program expanded in 1998 to address and link activities in reproductive health, child health, and nutrition. It aimed to be participatory in nature and streamlined enough to rapidly go to scale (i.e., 20 focus districts and 20 “less intensive” districts in both provinces). By 2002, more than 15,000 community “animators” from existing community groups were trained, reaching nearly 8 million people—or roughly half the country’s total population (BASICS II, 2004a).

A 2001 evaluation compared selected indicators in non-program areas with those in program areas and also with national averages taken from Ministry of Health data. According to the project evaluation (BASICS II, 2004a), there were a number of improvements, including the following:

- Coverage for all primary immunizations was similar across all provinces in Madagascar in 1997 (Macro International Inc. & INSTAT, 1998), but, in 2001, coverage in the program provinces was higher than coverage in both other provinces and the national average. Coverage in the 20 districts was significantly better than provincial and national coverage.
- Early initiation of breastfeeding increased in program sites from 34% in 2000 to 76% in 2002. In comparable non-program sites, the levels remained at around the national average of 35% (Macro International Inc. & INSTAT, 1998).
- Three-fourths of infants were exclusively breastfed in program areas, as compared with 40% in non-program areas.
- The overall contraceptive prevalence rate for modern methods in one of the two provinces increased from 5% in 1997 to 7% in 2000, while the rate in the program districts in this province increased to 15%.

## Pathways to Success

### Establish a “Package of Goals”

The process in Madagascar began with the development of a “package of goals.” Built on public health realities, the package was flexible, responsive to community needs, and practical. Its goals included reaching 80% vaccination for infants under 12 months, achieving 65% use of child health cards for those less than 3 years, and completing 10 family planning promotion sessions. This overall package did not change for each community (BASICS II, 2004b).

### Work with Communities to Set Priorities

The package preserved community decision-making and served as a base from which communities could prioritize. The intent was a balance of well-configured choices, such as 80% coverage for vaccinations or completion of a series of family planning counseling sessions. Experience supported the premise that when the number of goals is limited, communities can focus their attention and accomplish them. This seemed to increase the possibility of success and make scale-up easier.

#### **SUCCESS FACTOR**

##### *Keep it Simple and Flexible*

In Madagascar, communities chose their goals from a package that allowed them to be responsive to their particular needs and issues.

### Set Achievable Objectives

The Madagascar team believed in setting achievable objectives. “Communities like a starting point and a finish line. Translate the goals into do-able activities. Some are qualitative, some quantitative. Some are family-based, some are community-driven,” said Peter Gottert, the BASICS communications advisor in Madagascar. The key, he added, is a variety of activities and recognizing achievement in those varied activities. This recognition motivates the community from within.

#### **SUCCESS FACTOR**

##### *Recognize Achievement and Publicize Program Results*

In communities in Madagascar, children completing their vaccinations before their first birthday received a vaccination diploma that families proudly displayed. When 80% of the community received a diploma, the program would help organize a festival to celebrate the community’s successful vaccination rate. Reaching “Champion Community” status was a means to celebrate the community’s reaching a number of process indicators. This not only built excitement within the community but also reached beyond to neighboring communities and to donors.

### Commit to Established Community Groups

One of the first steps was to ask leaders to make a list of organizations active in each commune. These existing community organizations held responsibility and made key decisions such as: 1) whether they wanted to participate; 2) the two to three participants they would like to send for training; 3) how they would oversee the work of their volunteers after training; 4) how to attract new members; and, 5) whether to make home visits to extend their reach. Once volunteers were trained,

community “outsiders” did not get further involved in organizing them. Rather, that responsibility remained with the sponsoring group.

The organizations agreed that community volunteers were there to work in tandem with and amplify the voice of the health worker—to honor and build their capacity. The health workers organized the volunteers to provide educational and other types of support at the health center.

### Build “Champion Communities”

Some communities in Madagascar demonstrated higher levels of citizen participation, leadership, and social and inter-organizational networks. These communities were invited to become “Champion Communities” to raise their activity level even further. The invitation had a self-perpetuating effect on community capacity as the “Champion Communities” moved to a higher level of organization, often with local animators and community leaders as the driving force. Through ongoing celebrations of achievement and a focus on what works, these communities became highly motivated to achieve their package of goals. Thoughtful planning and mid-course corrections strengthened and simplified the process; hundreds of localities qualified to be “Champion Communities” (Gottert, 2000).

## SUCCESS FACTOR

### *Involve Partners from Other Sectors*

Although the project’s technical focus was health, establishing partners in other sectors, such as education or with women’s groups, developed a broad foundation for the project to achieve scale.

### Scale Out

The “Champion Communities” approach has moved beyond Madagascar. For example, USAID currently funds a bilateral program called Essential Services for Health in Ethiopia (ESHE). Managed by John Snow, Inc., ESHE is applying and expanding the approaches learned through the work in Madagascar. ESHE’s objective is to improve family health through an integrated program of child survival interventions as well as health sector reform.

## SUCCESS FACTOR

### *Develop Guides and Tools*

In Madagascar, counseling cards helped communities ensure message consistency throughout the project. A toolkit that included community tools, advocacy tools, and IEC materials enhanced access to quality health services.



## A Question of Time:

### Six Principles to Streamline Community-Based Programs

When compared to more traditional development approaches, many donors and cooperating agencies are concerned that community empowerment simply takes too long. The Madagascar program identified six strategies to streamline community mobilization.

- 1. Use simple, action-based messages.** The health messages focused on small, do-able actions that would obviously benefit the community and were feasible for rural families.
- 2. Develop easy-to-use tools.** The team identified three basic tools for frontline workers—the family health card, the women’s health card, and the youth passport—that were easy for workers to grasp and explain and for community members to understand and use. Keeping the tools relatively inexpensive was key so that distribution could be brought to large scale.
- 3. Focus on skill-based training.** The Madagascar project eliminated waste in training by focusing on the development of specific skills rather than the transmission of knowledge, and by working through local training teams. “The biggest challenge is to ensure that... workshops devote at least 50% of the time to practical exercises carried out by the participants.”
- 4. Recruit many volunteers.** The Madagascar program estimated a need to enlist as volunteers one percent of the population it intended to reach (or 2,000 volunteers for a region of 200,000). Massive use of volunteers ensured that the project worked through existing groups and ownership remained within the group.
- 5. Use mass media.** Because this project covered such a wide area (two provinces), mass media was essential to reinforce the key do-able messages and to sustain interest and enthusiasm.
- 6. Celebrate achievements.** Celebrations re-energize the community, attract interest (both from within and from outside the community), and build support. In Madagascar, celebrations took various forms, such as giving mothers a diploma when they completed a series of vaccinations and launching festivals whenever a community completed six months of health promotion.

Adapted from *Streamlining Community-based Programs: Six Guiding Principles of the Jereo Salama Isika Approach* (Gottert, 2000)



# Closing Reflections

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This report provides perspectives on community-based projects that worked at scale to create change beyond the individual level by valuing, supporting, and building empowered communities. Often the only measure of a health project's success is its ability to achieve positive health impact and change on an individual level. These case studies demonstrate that empowering processes can in fact ensure sustained individual and social change beyond the life of a program. The following reflections are intended to elicit further dialogue around the ideas presented in this paper.

## Starting Big or Small?

The case studies show that no magic formula or a prescriptive set of rules exists to successfully bring community empowerment to scale. While in some cases moving to scale too quickly (normally under external pressure to scale up fast) poses serious risks, in other cases community empowerment programs are designed from the onset to effectively operate on a large scale.

Madagascar and the Philippines piloted their initiatives in limited areas because a strong foundation was considered key for expansion. Results from the pilots guided the development of supportive training materials and monitoring tools. Demonstrated results led to expanded participation at multiple levels from government and the donor community. But the AWSO program covered several countries from the onset. All three programs eventually operated simultaneously at the community, district, regional, and national levels.

## Timelines and Numbers

In their book, *Just and Lasting Change*, Taylor-Ide and Taylor (2002) point out that one of the main requirements for successful scale-up is “patient persistence” by officials and experts in establishing a

favorable environment so trust and partnerships that support the capacity of people have time to mature. That type of environment—together with solid networks at the grassroots level—can help encourage and scale up community empowerment initiatives more quickly than is often believed possible.

## Partnership and Coordination

Partnership and coordination were crucial aspects that ensured the success of scaling up in the three stories. While it might be possible to implement a program in one setting with minimal inter-institutional support, going to scale is another proposition entirely. Programs require support at various levels (district, regional, and national), from various entities (government, NGO, private), from various sectors (agriculture, education), and from a variety of resources (financial, human, and material). Taylor and Taylor-Ide suggest communities must form partnerships with outsiders, officials, and experts. However, caution must be taken, they add, that infusion of outside resources (such as money, training, and technology) does not erode self-confidence and foster dependency. Outsiders and outside resources can stimulate commitment and support effective strategies but cannot do the actual work. A successful community effort results

from all three players working together, with community members guiding the process and outsider control and power relinquished to the community.

All three case studies forged political, institutional, and functional (sectoral) partnerships and went on to strengthen the various partners' organizational capacities and systems. They simultaneously and consciously fostered community self-confidence and a healthy interdependence among community members, officials, and outside experts. However, developing and strengthening partnerships is not always easy or possible, especially in environments where competition for funding prevails.

## Financial Realities of Continuity and Scaling Up

Stakeholders must engage in a pragmatic dialogue around the complex issues of funding. There are times when one partner is unwilling to relinquish control of the project. In cases where funding shifts to another agency, the original organization may feel a sense of ownership towards the materials developed and may be unwilling to share these developed resources. At the same time, it is often a challenge to get the necessary long-term funding to ensure continuity and to track, assess, and adapt a given model or set of tools while scaling up.

Continuity in all three country examples led to visible results. AWSO, for example, benefited from generous funding, and additional funds gained through NGO action facilitated its continuity over the years. Despite its sustained funding, AWSO faced a challenge common to many projects that try to acquire funding for adaptations or extensions after years of success. As the program coordinator noted, NGOs receive funding to use the tools and governmental institutions integrate tools into their programs, which is important. However, the external agency input often needed for the adaptation of materials and/or the design of new modules according to local (new, emerging) needs is not always possible due to lack of

funding. The funding agency may phase out and perceive that the NGOs and communities themselves can continue the work on their own—which is not always the case.

While aware of the need for external funding to be able to continue adapting and expanding successful models, CAs also seek to strike a balance between external support and community self-reliance—particularly in the framework of community empowerment programs. In these case studies, local partners and communities contributed financially or in-kind to the implementation of program activities. AWSO particularly illustrates this tactic.

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*We set agreements with interested partners to implement at least five workshops with their own funding. The memo of understanding clearly stated that they would receive videos and print materials from us, free of charge. But, the rest came from them. I think it was a brilliant arrangement because it engendered responsibility. They knew from the start, they'd be looking for their own funding so no dependency was built in. This is not unique, but it's rather unusual.*

- Carol Underwood, Senior Research Officer, CCP

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## Holding on to Core Values

The stories from Madagascar, the Philippines, and the Middle East are reminders to constantly pay attention to scale-up without losing the project's initial principles and values, especially when adapted to different contexts and needs. All three initiatives sought to maintain critical program components at scale and not lose sight of values and goals conveyed in the original model.

AWSO worked on the premise that knowledge emerges not from experts but from group dialogue at the grassroots level. The AWSO team focused the program on the perceived needs of Arab women and designed it in response to what women said was of interest to them. In

addition, the structure of the training allowed participants to direct the dialogue. While iterations of the program added content areas in response to local needs, specific behavioral objectives did not override broader project goals, such as increased self-determination and self-esteem. In the Philippines, the team successfully adapted the ACM approach to a new context—where the issue of conservation and preservation of coastal ecology was a primary concern—without losing sight of the overall goals of increasing self-determination and self-confidence. In the same vein, the Madagascar project offered a flexible “package of goals” presented to communities as a base from which they could prioritize.

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*An empowered community has self-determination. They have the capacity to learn from mistakes and move forward on the goals they have set. They are self-confident. They understand the importance of participation of the most marginalized. If the project is run by both those marginalized groups and those in power then there is equity as well, not only in terms of material things, but in the ability to express themselves and do something about their own condition. An empowered community has the ability to resolve conflicts in a positive way, and without external intervention. They have a goal which they have set and which they have organized around, including being able to mobilize resources both human and material.*

- Naida Pasion

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## Horizontal Learning

Community-to-community learning facilitates exponential growth of empowering grassroots initiatives, as networks of learning centers expand to include more communities. For instance, communities shared experiences through the Philippines’ model “learning schools” and Madagascar’s “Champion Communities.” This exchange of ideas and

knowledge motivated them to continue to learn from their daily practice, from CAs, and from other partners’ experiences. This “horizontal networking” (Gumucio Dagon, 2001) fosters a sense of healthy interdependence between and among communities and external agents in contrast to a predominant unilateral dependence of communities on outside agents.

## Decision-Making in the Hands of Local People and Communities

The three cases provide solid evidence in favor of local decision-making processes. All three offered training packages as a menu of options. Local facilitators decided with the community participants where to place the emphasis, depending on local strengths and needs. In AWSO, many decisions were left to local trainers. With ACM, community trainers worked with 10 to 14 couples at a time, facilitating relevant exercises from the FP Action Guide, mentoring couples on the FP Action Cards, and lining up testimonials according to the time and location suggested by participants.

## Fostering Local Ownership through Reflection and Action

The three cases illustrate how the growth of an initiative begins by increasing people’s awareness, fostering local ownership of activities, and building capacity through participatory empowering programs. This environment fosters the fundamental momentum for growth, and scale. The AWSO design started from the premise that dialogue is critical for action. The guidance provided by the “4-Ds” in the Philippines encouraged critical dialogue and reflection by communities, which in turn ignited interest and participation of those most affected in the transformation of their own reality.

## Emerging Questions

This report attempted to provide some answers to commonly asked questions regarding how and when community empowerment is best taken to scale. Most importantly, it sought to elicit questions and further reflection on this crucial topic. The authors found it challenging to find well-documented descriptions and evaluations of community empowerment programs. They suggest more emphasis is needed on both qualitative and quantitative documentation and encourage donors to continue supporting the documentation of empowerment and how changes in community capacity are evaluated. Several questions remain open for further investigation and dialogue among partners involved in community empowerment programs at different levels. The following questions emerged during the development of this paper and may help open up that dialogue:

- How can projects be supported to measure changes in community empowerment along with changes in health outcomes?
- When to start “big” and when to start “small”?
- How can a three-way partnership among communities, officials, and outside advisors best function in the context of competition for funding?
- How can organizations help preserve the values conveyed in their original program (e.g., equal participation, self-determination) while at the same

time giving up control on the adaptation of their model during the scaling-up process?

- How to strike a balance between external support/funding and the fostering of community self-reliance when a program goes to scale?

The authors believe future decisions for funding and program design need to be based on analysis of complex inter-relations between the key success factors highlighted in this paper, and on lessons learned about retaining empowering processes while expanding impact and scale. Donors and CAs must take into account specific needs, settings and circumstances as programs are designed and funded. The writers acknowledge the need for further documentation and evaluation of changes in empowerment as scale is achieved, and they encourage continued funding and focus on this effort.

The challenge remains to help increase the numbers of people empowered to access health services and sustain good health practices. Only by reflecting on program designs and funding priorities can we be prepared to do our best in the future.

# Appendix

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## Dimensions of Community Capacity

*Citizen participation* characterized by

- A strong participant base
- A diverse network that enables different interests to take collective action
- Benefits that override the costs associated with participation
- Citizen involvement in defining and resolving needs

*Leadership* characterized by

- The inclusion of formal and informal leaders
- Providing direction and structure for participants
- Encouraging participation from a diverse network of community participants
- Implementing procedures for ensuring participation from all during group meetings and events
- Facilitating the sharing of information and resources by participants and organizations
- Sharing and cultivating new leaders
- A responsive and accessible style
- The ability to focus on both task and process details
- Receptiveness to prudent innovation and risk-taking
- Connectedness to other leaders

*Skills* such as

- The ability to engage constructively in group process, conflict resolution, collection and analysis of assessment data, problem-solving and program planning, intervention design and implementation, evaluation, resource mobilization, and policy and media advocacy
- The ability to resist opposing or undesirable influences
- The ability to attain an optimal level of resource exchange (how much is being given and received)

*Resources* characterized by

- Access and sharing of resources that are both internal and external to a community
- Social capital, including the ability to generate trust, confidence, and cooperation
- The existence of communication channels within and outside a community

*Social and organizational networks* characterized by

- Reciprocal links throughout the overall network
- Frequent supportive interactions
- Overlap with other networks within a community
- The ability to form new associations
- A cooperative decision-making process

*Sense of community* characterized by

- High level of concern for community issues
- Respect, generosity, and service to others
- Sense of connection with the place and people
- Fulfillment of needs through membership

*Understanding of community history* characterized by

- Awareness of important social, political, and economic changes that have occurred both recently and further in the past
- Awareness of the types of organizations, community groups, and community sectors that are present
- Awareness of community standing relative to other communities

*Critical reflection* that is characterized by

- The ability to reflect on the assumptions underlying one's own and others' ideas and actions
- The ability to reason logically and analyze arguments
- The ability to understand how forces in the environment influence both individual and social behavior
- The ability for community organizations to analyze their own efforts at change over time

Adapted from Goodman (1998), *Identifying and Defining the Dimensions of Community Capacity as a Basis for Measurement*



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