Building healthy communities through community mobilisation

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Published in:
Health Promotion Practice

Publication date:
2015

Document version
Peer reviewed version

Citation for published version (APA):
Skovdal, M., & Valentine, P. (2015). Building healthy communities through community mobilisation. In *Health Promotion Practice* (2 ed.). Maidenhead: Open University Press.

8 Developing healthy communities through community mobilization

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Overview

The aim of this chapter is to address the role of community mobilization in developing healthy communities. The chapter provides a brief overview of community mobilization before moving on to introduce various tools and methods that can be used to mobilize communities. The chapter then illustrates how these tools can be applied in practice through a discussion of 'real world' projects. The chapter ends with a discussion of some of the challenges involved.

Learning objectives

After reading this chapter, you will be able to:

- explain the characteristics of community mobilization and its role in building healthy communities
- plan a programme that builds healthy communities through community mobilization
- understand how to use a variety of participatory tools to mobilize a community for better health
- describe the strengths and challenges inherent to community mobilization

Key terms

Community: A group of people who have something in common, such as living in the same geographical area or sharing common attitudes, interests or lifestyles.

Community development: An approach to development that seeks to increase the extent and effectiveness of community action, community activity, and agencies' relationships with communities.

Community mobilization: A capacity-building process through which local individuals, groups or organizations identify needs, plan, carry out and evaluate activities on a participatory and sustained basis, so as to improve health and other needs, based on their own initiative or stimulated by others.

Community participation: A process (and approach) whereby community members assume a level of responsibility and become agents for their own health and development.

Participatory Learning and Action (PLA): A collection of methods and approaches used in action research, which enable diverse groups and individuals to learn, work, and act together in a cooperative manner, to focus on issues of joint concern, identify challenges, and generate positive responses in a collaborative and democratic manner.

Characteristics of community mobilization

Early health promotion efforts were guided by strategies focused on individual-level behaviour change. However, as Chapter 5 explained, the Alma Ata Declaration of 1978 introduced a shift in thinking, recognizing the role of socio-economic and cultural factors in determining the health behaviour and practices of individuals, groups, and communities (WHO, 1978). This shift was further supported by the 1986 Ottawa Charter (WHO, 1986) and the 2005 Bangkok Charter (WHO, 2005). These Charters cemented a participatory rhetoric in public health, giving rise to community mobilization in health promotion. The theoretical underpinning of community mobilization as a means of health promotion is described in chapter 6 of *Health Promotion Theory* in the Understanding Public Health series (Skovdal, 2013).

Community mobilization means different things to different people and programmes therefore take different forms. Campbell (2014) highlights four approaches to community mobilization:

- *Instrumental approaches* whereby communities contribute to the implementation of programmes designed by 'health experts';
- *Dialogical approaches* that seek to facilitate dialogue between health promoters and community members, developing solutions that resonate with local realities;
- *Social capital approaches* that promote participation in formal and informal networks, for example women's and youth groups; and
- Approaches having a *critical* or *political emphasis* that use community mobilization as a conduit to challenge the social inequalities that leave people vulnerable.

Favouring a mix of the dialogical and social capital approaches, with some political emphasis, Howard-Grabman and Snetro (2003) define community mobilization as a capacity-building *process* through which local individuals, groups or organizations identify needs, plan, carry out and evaluate activities on a *participatory and sustained* basis, so as *to improve health and other needs*, based on their own initiative or stimulated by others. Key characteristics of good practice that underpin community mobilization are that it should:

- Build on the already existing community processes and structures, such as health committees, or other community development initiatives;
- Develop an ongoing dialogue between community members regarding health issues;
- Create or strengthen community-based organizations aimed at improving health;
- Assist in creating an environment in which individuals can empower themselves to address their own and their community's health and other needs;
- Promote community members' participation in ways that recognize diversity and equity, especially those who are most affected by health issues;
- Work in partnership with community members in all phases of a project to create locally appropriate and locally owned responses to health needs;

- Identify and support the creative potential of communities to develop a variety of strategies and approaches to improve health status and well-being;
- Assist in linking communities with external resources (organizations, funding, technical assistance); and
- Commit enough time to work with communities, or with a partner who works with them, to accomplish the above.

Given these characteristics, and in order to design a community mobilization strategy that is feasible, acceptable, and locally appropriate, it is also good practice to include a research component at the beginning to find out about the history of the community, what has gone before, the community power dynamics, the strengths, weaknesses, and opportunities associated with – and threats to – any possible intervention.

Activity 8.1

Communities are not homogeneous entities, and it is important for health promoters to define what they mean by 'community' in their community mobilization programme. This activity encourages you to reflect on the diversity of community.

1 Make a list of communities you belong to.
2 Think about what qualifies you to be a member of these communities and how each of these communities plays a role in facilitating your health and well-being.

Feedback

Your examples will show how diverse communities are, how they overlap, and how they influence behaviour. Communities tend to be tied together by having something in common. This might be a shared goal (for example, a women's group), history (for example, a group of ex-service people), belief system (for example, the Muslim community), interest or hobby (for example, football players), identity (for example, people living with HIV), or geographical space (for example, a village).

Participatory Learning and Action in community mobilization

Most health promoters looking to develop healthy communities through community mobilization draw on the Participatory Learning and Action (PLA) cycle. Guided by the works of Chambers (1983), Freire (1970), and Lewin (1946), the PLA cycle is used as a generic 'umbrella' term to describe a process whereby diverse groups and individuals come together to learn, work, and act in a cooperative manner, to focus on issues of joint concern, identify challenges, and generate positive responses in a collaborative and democratic manner. Figure 8.1 illustrates what a typical PLA cycle might look like.

There are many examples of how the PLA cycle has been adapted to community mobilization programming. This reflects the fact that there is effectively no single 'right way' to mobilize communities. However, all PLA approaches share the principle that increased knowledge can lead to action and empower communities to identify and act out solutions to local problems. Table 8.1 provides an overview of some of the ways in which a PLA approach has been used within community mobilization projects. The table demonstrates

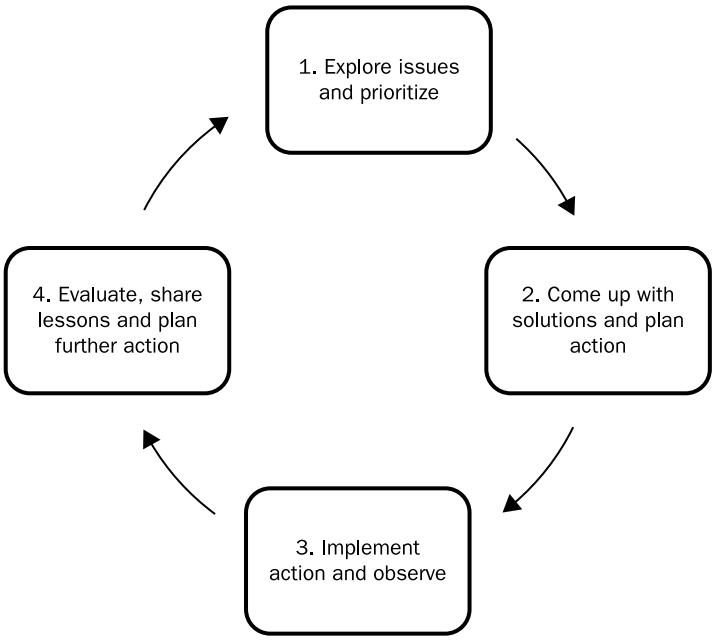

Figure 8.1 Typical PLA cycle diagram.

Table 8.1 Examples of PLA approaches to community mobilization for health

PLA approach	*Description*	*'How to' guides*
Community Action Cycles	Save the Children have developed Community Action Cycles (CAC) to describe its community mobilization programming that fosters a community-led process, through which those most affected explore, set priorities, plan, and act collectively towards better health outcomes. Steps in the CAC include preparing to mobilize; organizing for action; exploring the issues affecting access to and quality of health services and setting priorities; planning together; acting together; evaluating together; and 'scaling up' successful efforts. Each step of the CAC has a series of related activities that guide communities and facilitating partners.	Howard-Grabman and Snetro (2003)
Community Conversations	Although early versions of the Community Conversations (CC) approach have been part of development programming since the 1990s, the approach was modelled by the United Nations Development Programme (UNDP) in 2001 in their Community Capacity Enhancement Handbooks. Community Conversations provide community members with the opportunity to discuss sensitive and health-related issues. Through a series of conversations, a facilitator supports the community to identify key issues and solutions/actions that community members can take to improve health in their community.	Gueye *et al.* (2005)

(*Continued*)

Table 8.1 Continued

PLA approach	*Description*	*'How to' guides*
Women's groups	Women and Children First (UK), in collaboration with the Institute of Global Health at University College London, pioneered ways of working with women's groups to support women to identify and prioritize solutions that can address maternal, newborn, and child health problems. Groups of between 25 and 30 women meet regularly and use PLA methods to develop and implement low-tech solutions to their health problems.	Rosato *et al.* (2010)
Child-to-Child approach	The Child-to-Child (CtC) approach, developed by Professor David Morley of University College London, is an educational process that links children's learning with taking action to promote the health, well-being, and development of themselves, their families, and their communities. Through participating in Child-to-Child activities, the personal, physical, social, emotional, moral, and intellectual development of children is enhanced. The CtC methodology encourages children to work together to find solutions to real-life problems and to apply what they have learnt in their everyday lives. The children are also encouraged to share what they have learned with other children and other members of the community.	Bonati (undated)
Community-based capital cash transfers	The Ministry of Gender, Children and Social Development of Kenya, with support from the Ministry of Foreign Affairs of Denmark (DANIDA), implemented in the 1990s and 2000s a community capacity support programme (CCSP) that used PLA methods to help communities democratically prioritize problems faced by community members, identify solutions, and develop social action plans. Action plans were submitted to district level social development offices for approval and funds were transferred into community bank accounts, providing the communities with much needed capital to collectively implement their planned activities.	Skovdal *et al.* (2011)

that both community mobilization and the way in which a PLA approach can be used within these projects take many different forms.

Common to the PLA approaches is a commitment to use tools and techniques that can engage communities throughout the project cycle.

Tools, techniques, and methods to facilitate community mobilization

To help facilitate an inclusive, participatory, and empowering process whereby community members can plan, carry out, and evaluate activities that promote collective action to improve health and well-being, a number of PLA tools and techniques have been developed. In this, and the next section, we describe a range of these tools and techniques and illustrate how some of them have been used in 'real-life' programmes. The *Tools Together Now – 100 Participatory Tools to Mobilise Communities for HIV/AIDS* by the International HIV/AIDS Alliance offers a comprehensive compilation of participatory tools

and techniques (International HIV/AIDS Alliance, 2006). It groups these tools and techniques into seven categories:

1 *Mapping tools* seek to develop maps that contain information about local realities and practices.
2 *Time analysis tools* focus on temporal aspects of community life, looking for example at changes over time or between seasons.
3 *Linkages and relationships tools* seek to visualize the connections between different factors promoting or undermining health.
4 *Experiential tools* seek to bring forward community members' experiences.
5 *Prioritization and quantification tools* help community members seek consensus through ranking and scoring.
6 *Action planning techniques* systematize the planning and evaluation process.
7 *Training tools* prepare facilitators to use the tools in a flexible, engaged, inclusive, and participatory way.

Examples of such tools and techniques are described below and many others are available (International HIV/AIDS Alliance, 2006).

Tool 1: Photovoice

What is Photovoice?

Photovoice is an experiential tool that enables community members, including children, to identify, represent, and enhance their community and life circumstances through photography (Wang *et al.*, 1998). Photovoice can be used to explore issues and set priorities as well as to evaluate activities.

How do you use Photovoice?

There is no single way of using Photovoice, but it might include the following steps:

1 Participants *decide on a focus* for their photography (for example, causes and consequences of malnutrition)
2 Participants move around the community for an agreed period and *take pictures*. They can either use digital cameras, including camera phones if available, or disposable cameras.
3 Participants meet up again to *write or talk about their photos*. This could involve explaining the meaning behind each photo, the reason why the photo was taken, and the relevance of the topic to people in the community.
4 Participants then share their favourite pictures and captions, and collectively the community *reflect* on the pictures taken and *identify common themes*. These themes can be used to inform health promotion activities.

Tool 2: Problem tree (explore issues and prioritize)

What is a problem tree?

A problem tree is a linkages and relationships tool. It uses the drawing of a tree, including its roots, trunk, and branches, to identify and analyse the underlying causes and the

impact of an issue affecting health in the community. If, for example, after the use of another tool, such as Photovoice, diabetes was identified as a growing problem in the community, a problem tree can be used to identify the causes and effects of this problem. A problem tree can be used both to explore issues and to examine barriers to community mobilization success.

How do you use the problem tree tool?

1 Start by drawing the shape of a tree on a large piece of flipchart paper.
2 Write the issue identified by community members on the trunk of the tree (for example, diabetes).
3 By the roots of the tree encourage community members to discuss and record what they consider to be the underlying causes of this problem. For some of the main causes ask 'why do you think this might happen?' to spark debate and learning.
4 By the branches of the tree encourage community members to discuss and record the effects of this problem. Keeping with the example of diabetes, you might want to ask what the impact of this condition is for those affected, their family and friends, and other members of the community.
5 Discuss what the problem tree shows and how findings can be translated into solutions or actions.

Tool 3: Picture cards

What are picture cards?

Picture cards are a versatile tool that can be used in prioritization and quantification and in training. They are visual ways to facilitate understanding about community health issues and prioritize which issues are the most common and serious in the community. Picture cards are an especially effective tool to use with groups who have low levels of literacy. On one side of the card there is the picture, and on the other side are a series of questions the facilitator asks to prompt a group discussion about the issue.

How do you use picture cards?

1 The facilitator shows a series of 5–6 picture cards, each illustrating an issue, to the assembled group.
2 The facilitator asks questions to elicit their perceptions of the most common and serious illnesses affecting their community; the local name and connotations associated with the illness; and local practices and health actions carried out to seek care, prevent or manage the illness.
3 Through two-way dialogue the group learns correct and factual information about the issue. The facilitator is able to address negative cultural and traditional beliefs and practices in seeking health care, managing and preventing the illness.
4 The group ranks the issues that most affect their community and are the most common and serious.
5 The group choose which issue they would like to plan and take action on and vote with stones. The picture card with most stones is the health problem community members will address first.

Tool 4: Pairwise ranking

What is pairwise ranking?

Pairwise ranking is a prioritization and quantification tool that helps the community to identify preferences or priorities (Rifkin and Pridmore, 2001). In a matrix, items (for example, health problems or activities that act as solutions to health problems) are juxtaposed and community members vote on which item they wish to tackle first. The community can use this tool to prioritize and rank their preferences.

How do you use pairwise ranking?

1 Community members agree on a list of 4–8 items to be ranked. These items may be identified through another tool, such as Photovoice.
2 Draw a grid/matrix on flipchart paper with the items to be compared written at the top of the grid and again down the left-hand side (see Table 8.2).
3 Starting with the top-right square, ask participants to consider the two items and decide which one they think is more important. Compare items and record which one participants rate as most important for the remaining squares.
4 Count the preferences and rank the items.

Tool 5: Visioning how

What is visioning how?

Visioning how is an action planning tool that is used to flesh out plausible activities that could be included in an action plan. Visioning how thereby takes the health problem as prioritized by the community and maps out activities that can address this health problem.

Table 8.2 Example of pairwise ranking

Health problems	*Soil-transmitted helminths*	*Malaria*	*Dengue fever*	*Sleeping sickness*	*Dysentery*
Soil-transmitted helminths	—	Malaria	Soil-transmitted helminths	Soil-transmitted helminths	Dysentery
Malaria	—	—	Malaria	Malaria	Malaria
Dengue fever	—	—	—	Dengue fever	Dysentery
Sleeping sickness	—	—	—	—	Dysentery
Dysentery	—	—	—	—	—

Health problems	*No. of times considered more important*	*Rank*
Malaria	4	1
Dysentery	3	2
Soil-transmitted helminths	2	3
Dengue fever	1	4
Sleeping sickness	0	5

How do you use visioning how?

1 Ask the community members to close their eyes and take five minutes to think about what activities are likely to have the greatest impact on addressing the health issue they have decided to tackle.
2 Write a 'how' question based on the health issue the community wants to address. An example question could be: 'How can we address the problem of malaria in our community?'
3 Draw arrows coming from the 'how' question and encourage community members to give different suggestions as to how they can address the issue (for example, addressing malaria could involve increasing the use of mosquito nets). Record the different reasons by the different arrows.
4 By each of the suggested activities, draw some more arrows and explore how they will go about planning this, the resources required, etc. Record this information next to the different arrows.
5 Repeat this process until concrete plans have emerged and can be imported into an action plan.

If the community suggests many activities and needs to prioritize them, a prioritization tool can be used.

Tool 6: Action plan

What is an action plan?

An action plan is used to capture the results of the community's discussions during the PLA process, where the community carefully:

- describes the issues;
- sets priorities and specifies the objectives and desired results;
- details the activities for implementation and those responsible for implementing them;
- sets timelines.

Action plans are therefore key to the second step of the PLA cycle illustrated in Figure 8.1.

How do you develop an action plan?

A simple matrix may be used, such as the one shown in Figure 8.2. Participants may also wish to identify resources (human and material) and constraints that may help or hinder them in the pursuit of the results. The group may also want to detail the challenges that emerge from discussing the implications for implementation for each activity, and some results and activities may have to be re-evaluated and modified in the light of the challenges. Participants should decide how they are going to monitor the community's progress towards the desired results. It may be useful to design a monitoring matrix for this step, with the indicators down the left-hand side of the matrix and the following questions across the top:

- Who will be responsible for monitoring that indicator?
- How will that indicator be monitored?
- How often will it be monitored?
- What will the procedure be for reporting the monitoring results?
- What will the procedure be for reviewing and acting on the results of the monitoring?

Action Plan completed by:		**Date:**	
Name of clinic:		**District:**	
Village:		**Ward:**	
Problem	*Actions needed*	*Who is responsible*	*When (target date)*

Figure 8.2 Example of a simple action plan.

Tool 7: Log book

What is a log book?

A log book is an action planning tool that can be used to document progress in implementing an action plan. Log books can be used in the second and third steps of the PLA cycle illustrated in Figure 8.1. There may be many small sub-groups of the larger group who are implementing a variety of actions/activities at different times, which may be challenging to track for the facilitator or health committee members. A log book facilitates documentation and coordination between the main facilitator or committee members and the implementers.

How do you develop a log book?

A simple exercise book can be used by each group detailing the name of the activity being implemented, the date action took place, and progress on implementation. This information can be shared with other groups at the next community meeting and recorded on the 'master' action plan.

Tool 8: Community notice board

What is a community notice board?

A community notice board is a planning and evaluation tool, and can be used to share information and promote transparency and accountability by displaying results from activities carried out during the PLA process to the wider community (step 4 of Figure 8.1).

How do you develop a community notice board?

A notice board is positioned in a place where community members gather frequently, such as at a community centre, school, market place, health facility, district administrative headquarters or water collection point. The members of the community group regularly update the notice board, keeping the wider community informed about the activities implemented during the PLA cycle, the results of the action taken, successes, challenges, and lessons. It is hoped that sharing of information will create interest and motivate other community members to join in taking action, as well as creating a climate of accountability and transparency within the community.

Activity 8.2

It is the role of a PLA facilitator to use tools and techniques, like the ones described above, to empower communities to explore, plan, implement, and evaluate activities that promote their health. This activity encourages you to think about what skills, knowledge, attitudes, and behaviours a PLA facilitator needs by drawing a body map. Figure 8.3 illustrates how you can use the body (as a metaphor) to map out the characteristics of a PLA facilitator.

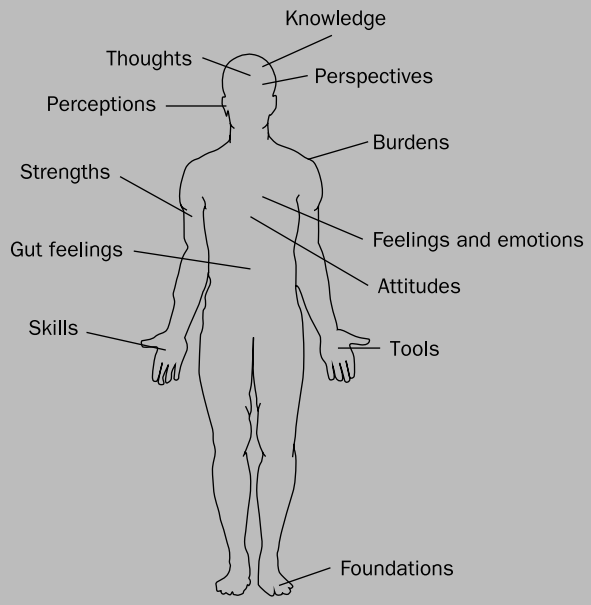

Figure 8.3 Body map with examples of body metaphors.

Draw a silhouette of a body. Use the body illustration to map out the skills, knowledge, attitudes, and behaviours a PLA facilitator needs (taking inspiration from the metaphors in Figure 8.3). Write down the knowledge, attitudes, and behaviours of a good PLA facilitator on the left side of the body, and the knowledge, attitudes, and behaviours of a poor PLA facilitator on the right of the body.

Feedback

A good PLA facilitator listens, can ask the right questions, has good interpersonal and mediation skills, is respectful, empathetic, non-judgemental, reflective of power hierarchies, inclusive, can build trust, can resolve conflicts, has in-depth knowledge of the health issue under study, can work as part of a team, has knowledge of PLA tools, is positive and enthusiastic. A poor PLA facilitator exhibits none of the above (see also example in Figure 8.4). The list above is not exhaustive and you may have identified many other qualities. The body map you have created is another example of a PLA tool.

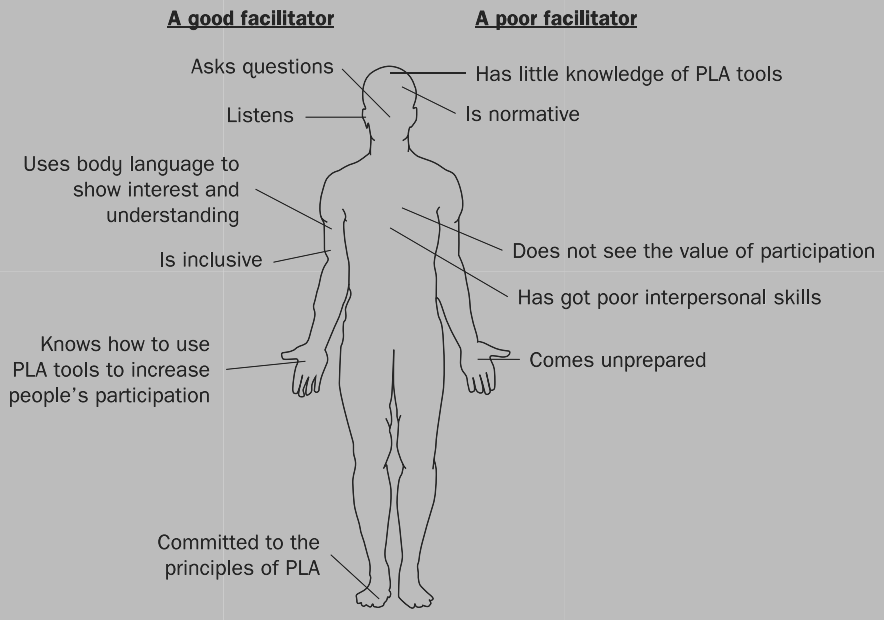

Figure 8.4 Body map of a good/poor facilitator

Case studies

To demonstrate how PLA tools can be used in practice, this chapter now describes two community mobilization programmes. The first is a large-scale programme (ACCESS) in Bangladesh and the second describes a smaller scale child-focused project in Kenya.

Case study 8.1: Community Action Cycle from Save the Children

ACCESS was a multi-country programme that was implemented in Bangladesh, Malawi, and Nigeria between 2006 and 2009. It aimed to reduce maternal and newborn deaths that result from pregnancy and childbirth complications by systematically engaging communities to improve maternal and newborn health (MNH) outcomes through Community Action Cycles, which is a tested and documented approach of community mobilization (ACCESS, 2010).

The programme's primary role was to support community mobilization for MNH by:

- Facilitating the integration of community mobilization with the broader national, regional or district health plan;
- Supporting implementing organizations (Ministry of Health, local government or non-governmental organizations [NGOs]) to develop community mobilization technical skills and expertise through training, targeted technical assistance, and joint development of guidelines, manuals, and supportive communication materials; and
- Monitoring progress of community mobilization efforts to refine strategies, energize stakeholders, and contribute to community mobilization expansion/scale-up planning.

The process described below maps out the steps taken and activities carried out to implement the ACCESS project. The phases refer to the phases of the Community Action Cycle described in Figure 8.5.

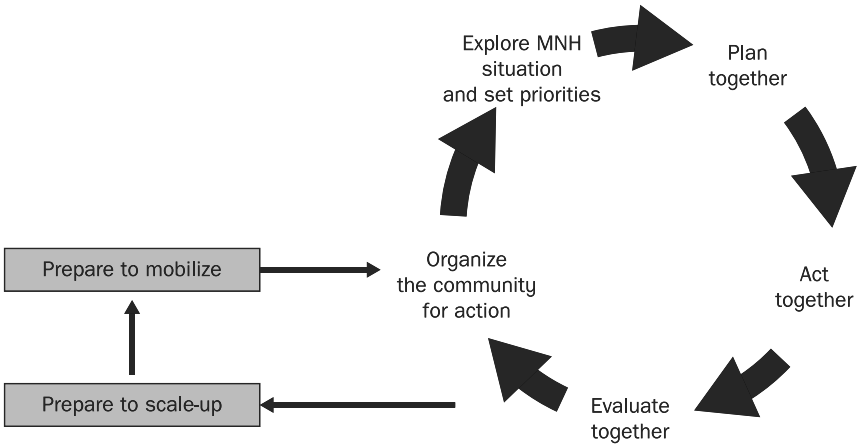

Figure 8.5 Community Action Cycle.

Preparing to mobilize phase

Step 1: Formative research was carried out in order to design a locally appropriate, context-specific community mobilization strategy for each country.

Organizing the community for action phase

Step 2: Individuals who were to facilitate the community mobilization process within communities were selected and trained.

Exploring the situation and setting priorities phase

Step 3: Activities were carried out to raise community awareness about the local MNH situation.

Step 4: Project staff worked with community leaders and other community members to invite and organize participation of those most affected by and interested in MNH.

Step 5: The facilitator explored with community members the local practices, beliefs, and attitudes that affect MNH.

Step 6: The community members were supported to set local priorities for action.

Planning together phase

Step 7: Facilitators helped community members develop and implement their own community action plans.

Acting together and evaluating together phases

Step 8: Facilitators worked with community members to build their capacity to independently monitor and evaluate their progress towards achieving improved health outcomes for mothers and newborns.

Table 8.3 summarizes the inputs and results of Community Action Cycles in Bangladesh. The development of skilled community mobilization facilitators was essential. None of the programmes provided monetary incentives to community members to organize, analyse, and address the local barriers to MNH in their communities. Those community members with heightened awareness of the problems faced by families acted collectively out of a desire to make a difference.

Table 8.3 Inputs and results matrix for the ACCESS Programme Bangladesh, February 2006 to July 2009: an NGO-led model (ACCESS, 2010)

Context	*Inputs*	*Results*
• Population covered by the intervention: approximately 795,000 • Most community health workers (CHWs) inactive and many vacant posts • Severely limited access to public, facility-based MNH services • No funding to strengthen public service delivery • Active NGO environment • Neonatal mortality rate: 37/1000 • Skilled attendance at birth: 11% • Total fertility rate: 3.7 • Modern contraceptive prevalence rate: 32%	• Community mobilization training manual, tools and communication materials developed • 125 NGO staff trained and supported to facilitate community mobilization • More than 2500 local leaders instructed on how to lead community mobilization efforts • 1904 Community Action Groups (CAGs) received monthly facilitation support • CAGs were composed of 21,875 men and women who participated to track pregnancies in their communities, and create and implement plans to encourage healthy home practices and remove barriers to use of services • 56% of CAGs included Ministry of Health staff	• 61% of CAGs generated community emergency funds (to date used by 619 families for transportation or doctors' fees, drug purchase or food) • 83% of CAGs organized emergency transport systems (to date used by 436 mothers and 247 newborns) for cases of obstructed labour, retained placenta, convulsions and (in the newborn) pneumonia, convulsions and jaundice, among others • CAGs re-opened 69 inactive clinics and EPI centres, and opened 12 new satellite clinics and 2 EPI centres, working closely with local government and NGO representatives

Activity 8.3

When designing large-scale community mobilization projects, it is important to think about what will be left after the project has ended at all levels of engagement (community, district, national levels).

1 How can you promote sustainability and ownership at all levels of the project?
2 How can you ensure that communities continue to take action over a sustained period?
3 How can you ensure the project reaches the most vulnerable and marginalized for a sustained period of time?

Feedback

- When designing your project, you will need to use formative research and pre-testing of concepts with the different levels of stakeholder to gauge what will motivate communities to engage over a sustained period.
- Research should look at: community power dynamics (for example, existing structures and opportunities); decision-makers and gatekeepers (for example, community and religious leaders); volunteer motivation and non-financial incentives (for example, for facilitators and participants, such as status, collective identity, respect); stakeholder analysis, power mapping, and consultation at higher levels to gain buy-in.
- The capacity-building of local non-governmental organizations (NGOs), civil society organizations (CSOs), and community-based organizations (CBOs), and their ability as partners to engage with community members over a longer period of time, can ensure that the most vulnerable and marginalized are reached (for example, organizations working with people living with HIV and disability; women's groups; children's clubs).

Case study 8.2: Strengthening the coping strategies of young carers in western Kenya

This community mobilization project was initiated by a local NGO in western Kenya in order to strengthen the coping and resilience of children caring for their sick parents or elderly grandparents (Skovdal, 2010). The project was made up of six PLA steps and engaged two rural, low-resource, and high-HIV prevalence communities.

Step 1 involved sensitizing the communities to the project and recruiting young carers. In partnership with community health workers, 48 young carers from the two communities were identified and invited to participate in the project. The young carers were aged 12–17 years.

Step 2 involved getting the young carers together in their respective communities (24 children from each community), introducing them to each other, to the NGO, and the aim of the project. To establish group dynamics, the young carers were provided with sports equipment and drawing materials and encouraged to meet up regularly.

Step 3 involved facilitating a number of participatory learning and action workshops to help the children identify and discuss their strengths, local coping resources and struggles. This involved using Photovoice (see above). After some training on how to use the disposable cameras they were given and the ethics of taking pictures, the children took photos, over a two-week period, guided by the following four questions:

- What is your life like?
- What is good about your life?
- What makes you strong?
- What needs to change?

When the children returned and all the photographs had been developed, they were invited to pick six of their favourite photographs, showing a mix of how they get by, things they lack, and something or someone who is important to them. They were then asked to reflect and write a story about each of their chosen photographs, prompted by the following questions:

- I want to share this photo because . . .
- What's the real story this photo tells?
- How does this story relate to your life and/or the lives of people in your community?

If the children wanted to write about a situation that they did not capture on camera, for ethical or practical reasons, they were encouraged to draw the situation.

Step 4 involved the young carers sharing their stories and observations from these participatory learning activities, identifying common struggles and coping strategies. Through prioritization tools, such as pairwise ranking and action planning techniques, the young carers drew on the themes emerging from their reflections and photos to decide on a list of activities to include in an action plan. Each of the two groups of young carers developed an action plan that would strengthen their coping and resilience. Both groups felt that they could benefit from learning how to run a small-scale enterprise. One of the groups of young carers therefore decided to engage in goat and chicken rearing and farming, while the other group decided to set up a small business selling corn.

Step 5 involved the NGO funding the action plans developed by the two groups of young carers and supporting them to implement the activities. This included providing the young carers with the necessary training to run a small-scale enterprise and conducting frequent visits to support and offer advice where required.

Step 6 involved evaluating progress of their activities. The young carers were invited to write a story about 'being part of a team', guided by the following three questions:

- What are your feelings about being part of a team?
- What, if anything, have you learnt from being part of a team?
- Why do you think that is?

The young carers were also invited to draw and write about their experiences. More specifically, they were encouraged to draw and write about: (i) the activities they implemented; (ii) those who were involved; (iii) a situation where they faced a problem. The essays and drawings were shared among the young carers in workshops, sparking debate about what they had learned and how they were able, as a collective, to overcome difficulties as they move forward.

Evidence on the effectiveness of community mobilization

Much has been written about community mobilization over the years and many lessons have been learnt from community mobilization programmes in both low-income and high-income countries. Although the evidence is mixed, the health-promoting potential of community mobilization programming is promising. This is demonstrated by a growing number of successful, tried-and-tested approaches to community mobilization. In the context of maternal, newborn, and child health, for example, researchers from the Institute of Global Health at University College London, have developed and tested an approach that involves training local female facilitators to establish women's groups and support a participatory and action-oriented process that strengthens the capacity of women in the community to take control of their health and that of their children (Prost *et al.*, 2013). The researchers found the application of this low-cost, scalable, and participatory model improves birth outcomes in a poor rural populations in Nepal (Manandhar *et al.*, 2004), India (Tripathy *et al.*, 2010), Bangladesh (Azad *et al.*, 2010), and Malawi (Lewycka *et al.*, 2013). There is also evidence that community mobilization efforts taken to scale have achieved significant health gains. For example, in Ethiopia a cluster randomized controlled trial showed that mobilizing women's groups to effectively recognize and treat malaria at home led to a 40% reduction in under-5 mortality (Kidane and Morrow, 2000). In Bolivia, as part of the Warmi project, women's groups, led by a locally recruited woman facilitator, and supported through a community mobilization action cycle, discussed maternal and newborn health problems. Strategies were developed, implemented, and assessed in cooperation with local leaders, men, and health workers. The project saw a 30% reduction in the neonatal mortality rate (O'Rourke *et al.*, 1998). A recent systematic review by Cornish *et al.* (2014) also demonstrates the potential of community mobilization in the context of HIV prevention.

Mobile technologies and social media are changing the social landscape and communication between people and organizations across the globe, offering new and exciting opportunities for community mobilization. The potential of mobile technologies to take the principles of community mobilization (i.e. facilitate critical awareness and empower people to push for change) to an unprecedented scale is set to transform health and development services globally (Zambrano and Seward, 2012). Future community mobilization programmes ought to harness current advances in mobile technology in community mobilization, both to enable people to challenge and address the social inequalities that leave them vulnerable in the first place, and to better engage with people in urban zones and areas with migratory and transient populations.

Challenges, uses, and abuses of community mobilization

While there are many examples of community mobilization strategies that have been successful in improving health outcomes throughout the world, not all community mobilization programmes succeed. Community mobilization is a process that depends on the interpersonal skills and attitudes of the stakeholders involved. To help circumvent and prepare for some of the many challenges related to community mobilization, this chapter now outlines some common pitfalls.

- *Power relations* – it is important to be aware of the power relationships within a community. Communities experience power dynamics and politics that are difficult for outside facilitators to understand. Be aware of gender dynamics; the sensitivity of certain topics; tensions between old and young; feuds between families and

neighbours; the role of community leaders; difficulties in agreeing on community priorities and planned actions, responsibilities, and timescales.

- *Capacity-building* – care should be taken not to underestimate the need for capacity-building. Inadequate support and training can lead to community apathy, frustration, and demotivation, resulting in inaction. Equally, capacity-building activities should not assume that community members have no knowledge or experience to incorporate and build on.
- *Time commitments* – community mobilization is a time-consuming process, requiring commitment from both the facilitating agency and from community members. For community members, volunteering time can be a challenge, and some community members may feel overstretched and burdened by the process.

In addition to recognizing some of the challenges inherent to community mobilization, health promoters facilitating community mobilization projects need to be aware of the risk of more powerful stakeholders hijacking and taking advantage of what community mobilization projects can offer, or in some cases, disguise, in order to support their own agenda. Potential 'uses and abuses' (cf. White, 1996; Cooke and Kothari, 2001; Mosse, 2001) of community mobilization to be aware of include:

- *'Facipulation'* – this terms describes the process by which community mobilization can be used as a guise to manipulate participants in a particular direction. In particular, the process of facilitating community mobilization can be steered and guided to different degrees and in different ways, with the risk that some community mobilization projects may be 'facipulated' to convince local people of the agendas of others.
- *Appropriateness* – it is possible that community mobilization and participation may carry more significance for health promoters than it does for the communities participating. This is particularly the case where challenging power relations and the status quo may be detrimental to the community and may leave them more vulnerable, marginalized, and exposed in some hostile environments.
- *Cheap solution* – despite the health promotion potential of community mobilization, it is not the responsibility of community members to substitute the role and responsibilities of health institutions and structures. Community mobilization should therefore not be used as a justification for avoiding necessary health and welfare spending or seen as a cheaper goal than reducing income inequalities.

Despite these challenges and potential 'uses and abuses', community mobilization continues to be ethically and practically fundamental to developing health-enabling community contexts.

Activity 8.4

In this activity you will conduct a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis of a programme looking to develop healthy communities through community mobilization.

EITHER re-visit one of the two community mobilization programme case studies above to do this hypothetically, OR think of a community mobilization programme you are familiar with. Consider the strengths, weaknesses, opportunities, and threats of the programme by completing a SWOT diagram (as illustrated in Figure 8.6). Strengths and weaknesses refer to internal factors facilitating or inhibiting the programme, while opportunities and threats refer to external factors.

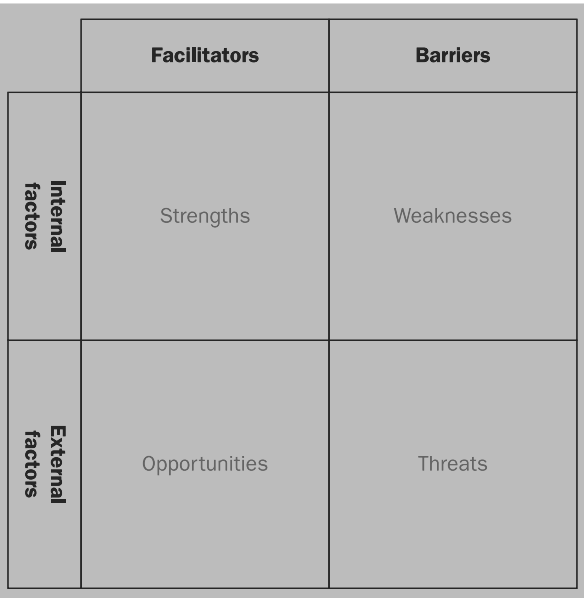

Figure 8.6 SWOT diagram.

Feedback

Through this process you should have identified both internal and external factors serving as either barriers or facilitators in achieving the objective of community mobilization activities. Figure 8.7 highlights what some of the factors might be.

	Facilitators	Barriers
Internal factors	**Strengths** • The quality of the PLA facilitator • Programme planning • Capacity-building • Partnership between agency and community	**Weaknesses** • Poor leadership • Elements of facipulation • Limited time available
External factors	**Opportunities** • Use of new mobile technologies • Integration of activities into health services • National policies • Community mobilization is valued by stakeholders	**Threats** • Power imbalances within the community • Weather (such as drought) • Funding is limited or cut short • Conflict

Figure 8.7 Potential strengths, weaknesses, opportunities, and threats.

Summary

This chapter has introduced you to community mobilization and offered a series of tools and approaches that can help you build healthy communities through community mobilization. More specifically, you have learnt about the PLA cycle and how it can be flexibly adapted to different contexts, as long as it offers community members the opportunity to develop a critical perspective about their health needs and the chance to develop community-driven responses. You have been introduced to specific tools and methods for facilitating participatory learning and action, and seen how these tools can be applied in both small- and large-scale community mobilization programmes. You have also covered some of the potential challenges and 'uses and abuses' of community mobilization programmes.

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Further reading

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