



# At a glance

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## Appreciative Community Mobilization (ACM) Increases Contraceptive Use in the Philippines

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### Introduction

The growing body of evidence in the international development field repeatedly demonstrates that communities can make deep and lasting contributions to their own health and well-being — and, through example and imitation, to the health and well-being of other communities!. Consider:

**Community mobilization is a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.**

- In **Bolivia**, 50 poor, isolated communities cut newborn mortality by more than half in three years. Families adopted many healthier practices, developed emergency transport and financial support systems and, most importantly, increased women's participation and status in community decision-making. This community mobilization approach was later expanded to over 500 communities in Bolivia and was adapted for use in many other countries. (*The Warmi Demonstration Project, 1990-1994*)
- In **Vietnam**, communities improved children's nutritional status by learning from their own residents what existing local foods and practices could lead to healthy nutritional status. This "positive deviance" approach not only improved participating children's nutritional status, but years later their younger siblings were also found to have good nutritional status. Neighboring communities learned how to apply the positive deviance approach through "Living Universities," and it is now being used in a number of other countries and also being applied to other health issues. (*The Poverty Alleviation and Nutrition Project (PANP), 1991-1993*)
- In rural **Peru**, where services were underutilized and a large sociocultural gap existed between service providers and community members, service providers and communities came together to jointly define "quality of care" and improve health services according to this joint definition. Relations between providers and communities greatly improved, Ministry of Health staff reported increased utilization of services, and clients reported greater satisfaction with the quality of care. (*"Building Bridges to Quality" methodology, 1998-present*)
- In the **Philippines**, communities used "Appreciative Community Mobilization" to improve family health. Building on their own assets, strengths, and experience, community leaders changed the way they made decisions to allow for the participation of the community's "priority families," those whose health and other indicators demonstrated that they could use more community support. These communities subsequently reported improved child health indicators and increased use of family planning methods. Significantly, participating communities also learned how to access municipal resources, advocate for policy changes, and monitor their progress. (*"Kalasugan Sa Pamilya- Appreciative Community Mobilization" project, Iloilo, 1997-present*)

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Community mobilization is a proven approach to development that has helped people around the world identify and address pressing health care concerns. The approach not only helps people improve their health and living conditions, but by its very nature strengthens and enhances the ability of the community to work together toward any goal that is important to its members. The result of a successful community mobilization effort, in other words, is not only a "problem solved" but the increased capacity to solve other problems as well (see pages 4-5 for more information on the CM and ACM process).

This issue of *At A Glance* focuses on the application of Appreciative Community Mobilization (ACM) to improve use of family planning (FP) in the Philippines. Contraceptive prevalence increased from 38% in 2002 to 45% in 2003. Marginalized groups in the community particularly benefited from the community mobilization process, as mentioned above. NGO Networks for Health funded a case study focusing on the "value added" of the ACM process to reducing barriers to FP adoption and use in both urban and rural settings<sup>2</sup>. A selected summary of the case study report follows.

### *The Kalusagan sa Pamilya (KSP) Project Background*

The *Kalusagan sa Pamilya* (KSP) project was conceived<sup>3</sup> in 1997 to test the application of the ACM process to increase the utilization of FP and child survival services delivered by the public health centers. It also aimed to position FP as a social norm and advocate for municipal or city legislation that would provide support for the improved delivery of FP and child survival services.

## PROJECT COVERAGE

### Iloilo City (Urban)

- 4,325 families
- 22,337 population

### Iloilo Province (Rural)

- 1,450 families
- 8,063 population

ACM was used as a strategy to complement the mass communication approach. The ACM strategy aimed to:

- Develop a method for motivational communication to increase utilization of FP and child survival services;
- Develop a working community referral system for couples wanting to plan their families and to ensure sustained practice of those who are already using modern methods of FP;
- Provide an effective venue for continuing dialogues between community members and health service providers; and
- Mobilize communities to support and utilize FP and child survival activities.

The KSP project was piloted in 16 rural and urban communities in the province of Iloilo, with support (to Save the Children) from Johns Hopkins University's Population Communication Services 4 Program (PCS4).

Using ACM, KSP built on existing community (*barangay*) and local government structures. It utilized human resources such as local leaders, Community Volunteer Health Workers (CVHWs), local government committee members, and Department of Health staff members. The project also made use of Department of Health facilities.

The KSP project was implemented using two cycles of the 4D approach (please refer to page 5 of pullout section):

- The first cycle (from mid-1999 through the end of 2000) targeted broad concerns around family health such as environmental health interventions in child survival (e.g., making safe water available, constructing community toilets).
- The second cycle (from the end of 2000 through the end of 2001) focused on FP.

In non-intervention communities, a radio campaign was ongoing and some Information, Education and Communication (IEC) materials were provided to public health centers. In addition, signs were posted at the clinics to indicate that FP and child survival services were available. These same activities occurred in the intervention communities.

The lessons learned through programming with joint FP and development concerns were carried on to the next project, People and Environment Co-Existence Development (PESCO-Dev) Project. PESCO-Dev explored the synergy of linking population, health, and environment in one single program. It aimed to increase the use of modern FP methods in coastal communities, using the platform of population and environment interlink.

PESCO-Dev successfully integrated FP with other program interventions just as KSP had done. In the case of PESCO-Dev, FP interventions were combined with coastal resource management activities. This combination proved successful in increasing consciousness and use of FP. Target groups in KSP and PESCO-Dev project sites received the integrated FP messages more readily than they received messages with an exclusive focus on FP. Both the KSP and PESCO-Dev projects used ACM to address barriers relevant to adoption and use of family planning.

### Case Study Results

Interviews were conducted with 175 couples of reproductive age in both the ACM (94 couples) and non-ACM (81 couples) areas. Approximately 67 percent of all couples interviewed were from rural areas and 70 percent were considered marginalized. Both acceptors and non-acceptors of FP were interviewed, but most of the couples classified as acceptors of FP were exposed to the ACM process. The interviews with couples were supplemented by interviews and focus group discussions with local government officials, health center staff, parish priests, FP volunteers, and Save the Children staff. The following presentation of results, however, will focus solely on the key informant interviews with couples.

**Table 1: A Profile of Family Planning Acceptors and Non-Acceptors**

Socio-Demographic Variables	Acceptors (n=99)		Non-Acceptors (n=76)	
	Husband/ Male	Wife/ Female	Husband/ Male	Wife/ Female
<b>Age</b>				
Mean Age	35	32	37	35
Age 30 and younger (%)	28	47	24	35
<b>Religion</b>				
Catholic (%)	78	76	85	78
Other (%)	22	24	15	22
<b>Educational Attainment</b>				
At least high school (%)	69	78	61	78
Mean number of years in school	8	9	8	9
<b>Number of Children Alive*</b>				
Mean	3.5		3.9	
Have more than 4 children (%)	27		35	

\*These responses were given by couples, not by individuals.

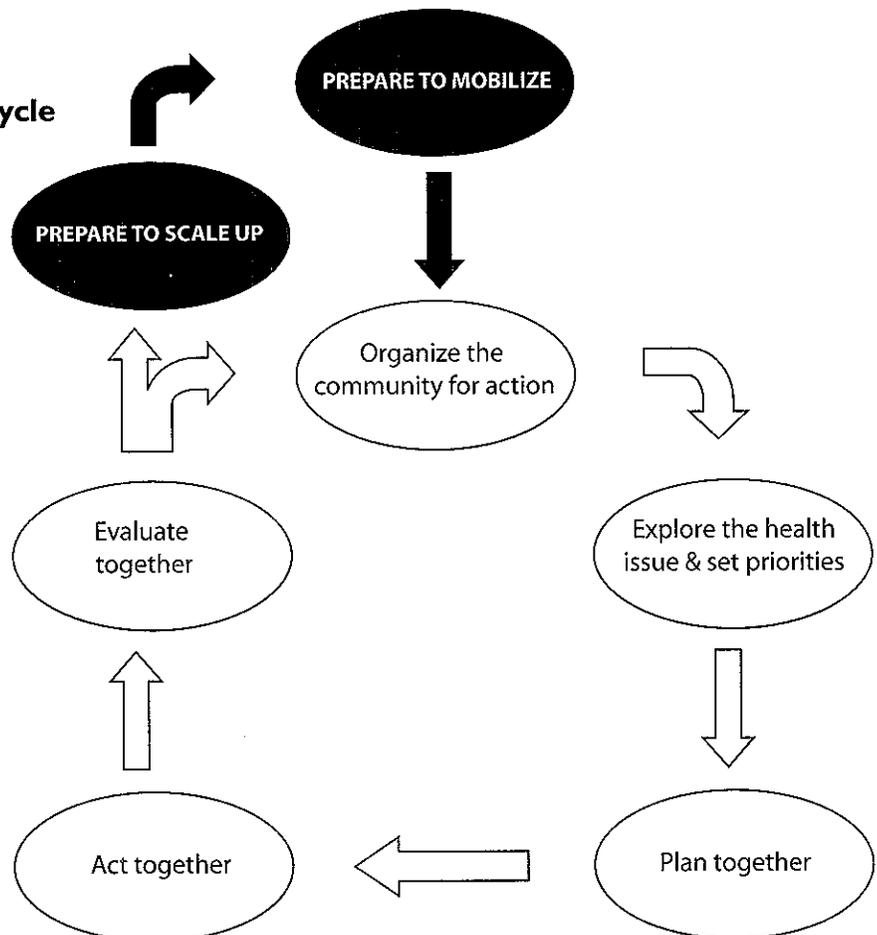
## Community Mobilization for Health and Social Change<sup>+</sup> (excerpted from the manual)

### The Path to Social Change: the Community Action Cycle

In the Philippines and other countries where community mobilization has been implemented, communities have followed a process known as the Community Action Cycle. This process draws on many of the theories and concepts of a social systems approach to individual and social change. It has been defined as “a process of public and private dialogue through which people define who they are, what they want, and how they can get it.” While there are numerous models of how social change can come about, they all share certain fundamental elements – which are also the guiding principles of community mobilization. These are:

- Sustainability of social change is more likely if the individuals and communities most affected own the process and content of communication.
- Communication for social change should be empowering, horizontal (versus top-down), give a voice to the previously-unheard members of the community, and be biased towards the local content and ownership.
- Communities should be the agents of their own change.
- Emphasis should shift from persuasion and the transmission of information from outside technical experts to support for dialogue, debate, and negotiation on issues that resonate with members of the community.
- Emphasis on outcomes should shift away from individual behavior to social norms, policies, culture, and the supporting environment.

**Diagram of Community Action Cycle**



## Appreciative Community Mobilization: Illustration from the Kalusagan sa Pamilya (KSP) project in the Philippines<sup>5</sup>

ACM combined two approaches: Appreciative Inquiry (AI) and Community Mobilization (CM). AI builds on the community's strengths, such as positive community values, successful moments, achievements, best practices and resources. CM is a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.<sup>6</sup>

ACM follows the 4-D cycle described below:

### **D-ISCOVERY** (What is)

This first phase of the cycle looks at the strengths and assets of the community that can be used as a foundation for sustained efforts in child survival and FP. During the discovery phase, communities ask themselves the following questions:

- What are our best practices in child survival and FP?
- What resources do we have which we can use to enhance child survival and FP outcomes?

### **D-REAM** (What might be)

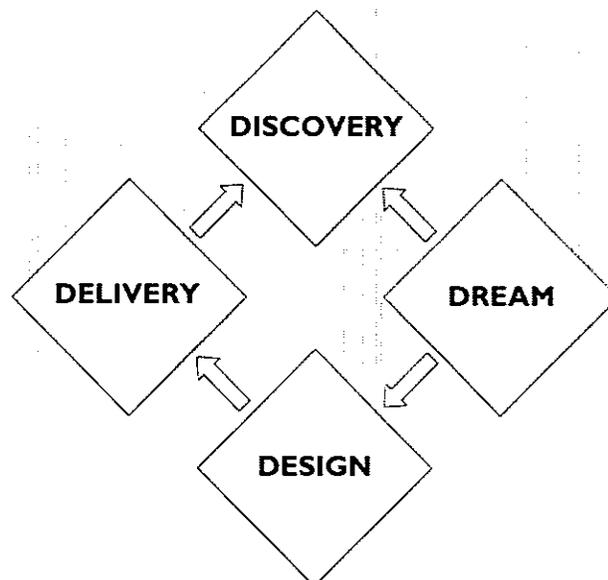
In this phase, community members articulate their desires and aspirations related to child survival and FP. Conducting sessions among the *sitios* (neighborhood) leaders, and not just among the *barangay* (village) officials, makes it possible for the "voiceless members of the community to express their desired future and become part of building the village's health dream.

### **D-ESIGN** (What should be)

In the design phase, community members develop their short-term objectives (to be completed within three years) to serve as the bridge between what they have now (discovery) and what they want to attain (dream). They also decide on the organizational structure that would best serve their purpose, and the manner by which they will monitor their collective accomplishment.

### **D-ELIVERY** (What will be)

These are the immediate steps that will ensure community action. This corresponds to a three-month action plan, mobilizing the broadest possible participation of village members, especially the priority (marginalized) groups.



## Profile of Couples

A selected profile of the couples that either accepted or did not accept FP is presented in Table 1. In general, couples that accepted FP were slightly younger than those couples that did not. Most of the couples were Catholic. There was little difference in education between the female acceptors and non-acceptors. However, male acceptors were more likely to have attained a high school degree than were male non-acceptors. The mean number of living children for non-acceptors (3.9) was very slightly higher than for acceptors (3.5). The family income for all couples interviewed was low.

## Interest in Use of Family Planning

Most of the respondents were initially exposed to the concept of FP during the latter part of their teenage years, with a mean age of 17.6 years among male FP acceptors and 18.7 years among the male non-acceptors. The results indicate that a very high proportion of both acceptors and non-acceptors developed an interest in FP after the initial exposure. However, the time interval between the initial exposure and the development of interest was quite long, with at least half of both acceptors and non-acceptors having developed the interest more than five years after their initial exposure.

Differences were found in the interest in FP exhibited by acceptors and non-acceptors. Compared to the acceptors, the non-acceptors were:

- less likely to think that FP was applicable to their personal lives;
- more likely to have disagreements about FP before getting interested in it as a couple;
- less likely to talk to someone as an individual or as a couple about their interest in FP;
- less likely to talk to health workers, especially the Barangay Health Workers (BHWs) and the FP volunteers, but more likely to consult relatives and friends about their interest in FP.

The results are presented in Table 2.

**Table 2. Comparison of Family Planning Acceptors and Non-Acceptors According to Selected Variables Related to Development of an Interest in Using Family Planning**

	Acceptors (n)		Non-Acceptors (n)	
	Husband/ Male	Wife/ Female	Husband/ Male	Wife/ Female
Thought that FP could be applied to their personal lives (%)	(99) 94	(99) 100	(76) 83	(76) 85
Time interval between first exposure to FP and development of interest in FP (%):				
1 year	(99) 13	(99) 17	(76) 18	(76) 24
2-5 years	25	21	21	26
>5 years	62	63	61	50
Said that having a partner contributed to development of interest in FP (%)	(99) 91	(99) 95	(48) 90	(52) 87
Disagreed about FP before both became interested in FP (%)*	(99) 4		(37) 16	
Talked to someone about interest in FP (%)*	(99) 72		(43) 42	
Who talked to person consulted (%):*	(99)		(16)	
Individual (husband or wife alone)	80		94	
Couple	20		6	

\*These responses were given by couples, not by individuals.

## Intention to Use Family Planning

The results in Table 3 on the following page show that there are several differences between acceptors and non-acceptors in terms of the attitudes and practices related to their intention to use FP. The reasons behind intention to use FP most cited by acceptors were a desire to limit births, along with economic and financial reasons. However, the non-acceptors were more interested in birth spacing and providing a better quality of life for their children.

Acceptors were more likely to talk to someone about their intention to use FP, while fewer than half (48%) of the interested non-acceptors were likely to do so. Most of the acceptors chose to talk to a midwife, while non-acceptors were likely to consult relatives, friends, nurses, and doctors in addition to midwives. In these conversations, most acceptors discussed the proper use of the different FP methods. Non-acceptors, on the other hand, were more likely to discuss the health aspects (such as side effects) of using FP methods.

## Family Planning Use

Approximately two-thirds (61-66%) of the acceptors took less than a year to convert their intention to use FP into practice. A high

**Table 3. Comparison of Family Planning Acceptors and Non-Acceptors According to Selected Variables Related to Having the Intention to Use Family Planning**

	Acceptors (n)*		Non-Acceptors (n)*	
	Husband/ Male	Wife/ Female	Husband/ Male	Wife/ Female
Reason for having the intention to use FP (%):	(98)	(99)	(33)	(38)
To limit births	31	34	6	3
For child spacing	10	20	55	71
For economic/financial reasons	32	24	9	5
To provide better quality of life for children	15	11	21	13
For health reasons	4	7	6	5
Other	8	3	3	3
Talked to someone about their intention to use FP (%)**	(99)		(29)	
	81		48	
Person consulted about intention to use FP (%):**	(81)		(14)	
Midwife	64		29	
Nurses/Doctors	11		21	
BHW/FP Volunteer	12		7	
Relatives/Friends	12		43	
Topic discussed with person consulted (%):**	(81)		(14)	
How to use different methods	56		-	
Choosing the best method	25		21	
Benefits of FP methods	7		7	
Health aspects/side effects	5		71	

\*Non-acceptors were only asked to answer intention-related questions if they were aware of FP and had developed an interest in using it. Hence, just under half of the original number of non-acceptors answered the questions related to this variable. All of the acceptors were allowed to respond to these questions.

\*\*These responses were given by couples, not by individuals.

proportion (89%) of these acceptors consulted someone about their decision to use FP. Most of them (67%) consulted a midwife, while only two percent opted to discuss their decision with relatives or friends.

For 87 percent of acceptors, the decision to use FP was usually reached as a couple, with hardly any disagreements at all. A high proportion (86%) of couples expressed satisfaction with the first FP method selected. However, at the time of the interviews, only about two-thirds (63%) of the acceptors were still using the original method used. These data are shown in Table 4.

**Table 4. Factors Influencing Use of Family Planning among Acceptors**

Factor influencing Family Planning use	Acceptors (n)	
	Husband/Male	Wife/Female
Time interval (in years) between intention to use a FP method and the time method was accepted (%):	(99)	(99)
1 year	66	61
2-5 years	18	13
>5 years	5	5
Not quantified	11	12
Talked to someone about their decision to use family planning (%)*	(99)	89
Who was consulted about intention to use FP (%):*	(88)	
Midwife	67	
Nurses/Doctors	16	
BHW/FP Volunteer	15	
Relatives/Friends	2	
Who decided to use a FP method*	(99)	
Individual (husband/wife alone)	13	
Couple	87	
Disagreed on the choice of FP method (%)*	(99)	
	2	
Were satisfied with the FP method selected (%)*	(99)	
	86	
Were still using the original FP method selected at the time of interview (%)*	(99)	
	63	

\*These response were given by couples, not by individuals.

## Conclusion

Appreciative Community Mobilization proved invaluable in increasing the acceptance and use of family planning (e.g. CPR increase of 7 percentage points in less than two years) and enhanced the ability of couples to communicate with each other and with health providers regarding their interest in family planning, including the use of different modern methods. The process also reduced the stigma associated with community and family level discussions of family planning and positioned it as a positive social norm.

More specifically, the ACM approach was considered to be more effective in increasing FP acceptance and use than other communication strategies alone (e.g. radio, interpersonal communication and counseling, television) for the following reasons:

- ACM was able to address people's fears and misconceptions of FP, many of which were not adequately addressed by mass media and individual counseling alone;
- ACM addressed social norms influencing FP, and identified and addressed relevant barriers (e.g., physical, moral, provider bias) affecting adoption and use of FP.
- The community and couples's sessions influenced the behavior of couples (i.e., moved them from pre-contemplation to intention to utilization) by creating a safe space for couples to talk;

- ACM encouraged the participation of marginalized or priority groups and encouraged leaders to integrate these groups into the community decision-making and planning processes. An important part of the project strategy was to reach the more marginalized groups;
- ACM utilized an appreciative rather than a problem posing approach. This approach was considered inclusive and non-threatening; and,
- ACM recognized the role of group pressure in increasing access to FP and other health services. With this recognition, ACM held health service providers and community leaders more accountable.

## Endnotes

<sup>1</sup> Howard-Grabman, L., and Snetro, G., (2003) *How to Mobilize Communities for Health and Social Change: A Health Communication Partnership Field Guide*. Health Communication Partnership.

<sup>2</sup> Paison, N, and Mendoza, O., (2003) *Philippines: Addressing Barriers in Family Planning through Appreciative Community Mobilization*.

<sup>3</sup> Save the Children, Philippines., (2002) *Mobilizing Communities for Family Planning and Child Survival: The Kalusugan Sa Pamilya (KSP) Project. Final Report*.

<sup>4</sup> Howard-Grabman, L., and Snetro, G., (2003) *How to Mobilize Communities for Health and Social Change: A Health Communication Partnership Field Guide*. Health Communication Partnership.

<sup>5</sup> Save the Children, Philippines., (2002) *Mobilizing Communities for Family Planning and Child Survival: The Kalusugan Sa Pamilya (KSP) Project Final Report*.

<sup>6</sup> Howard-Grabman, L., and Snetro, G., (2003) *How to Mobilize Communities for Health and Social Change: A Health Communication Partnership Field Guide*. Health Communication Partnership.

NGO Networks for Health (*Networks*) is an innovative five year global health partnership created to meet the burgeoning demand for quality family planning, reproductive health, child survival, and HIV/AIDS information and services around the world. Funded by the United States Agency for International Development (USAID), the project began operations in June 1998. For more information, contact:

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