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MaMoni

Integrated Safe Motherhood, Newborn Care and Family Planning Project

Community Mobilization Strategy

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MCHIP MaMoni Project
Community Mobilization Strategy

Introduction

Community Mobilization (CM) is one of MaMoni's key strategies for improving maternal and newborn health and use of family planning. This document outlines MaMoni's CM-related goals and objectives, as well as the key processes, roles and responsibilities related to CM actors and activities. The Community Action Cycle (CAC) remains the guiding process behind CM, but there are several major changes in how the project will roll out CM activities compared to ACCESS. The changes are elaborated in this document, but briefly they include:

- Community Volunteers (CVs) initiating and leading the CM process within their villages with minimal hands-on facilitation support. Instead, project staff will provide capacity building support to enable CVs to take on this role more independently from the beginning.
- A shorter timeframe required to complete development of community action plans – now estimated at 6 months per village, compared to 7-9 months under ACCESS.
- Whenever possible, one Community Action Group (CAG) per village composed of women and men. Male and female core groups may continue to explore and prioritize MNH/FP issues separately, but CVs will facilitate formation a single CAG responsible for coordinating implementation and monitoring of one community action plan.
- More engagement of Union Parishad members as partners in supporting CM, including establishment of CV committees that act as advocacy groups and provide regular input to Union Parishad planning and resource allocation.

General CM goal within MaMoni

This remains unchanged from ACCESS. The goal of CM is to increase community capacity to collectively analyze, plan, implement, and evaluate actions to improve maternal and neonatal health and prevent MN morbidity and mortality, including increased use of family planning in 7 Upazillas of Sylhet district and 8 Upazillas of Habiganj district.

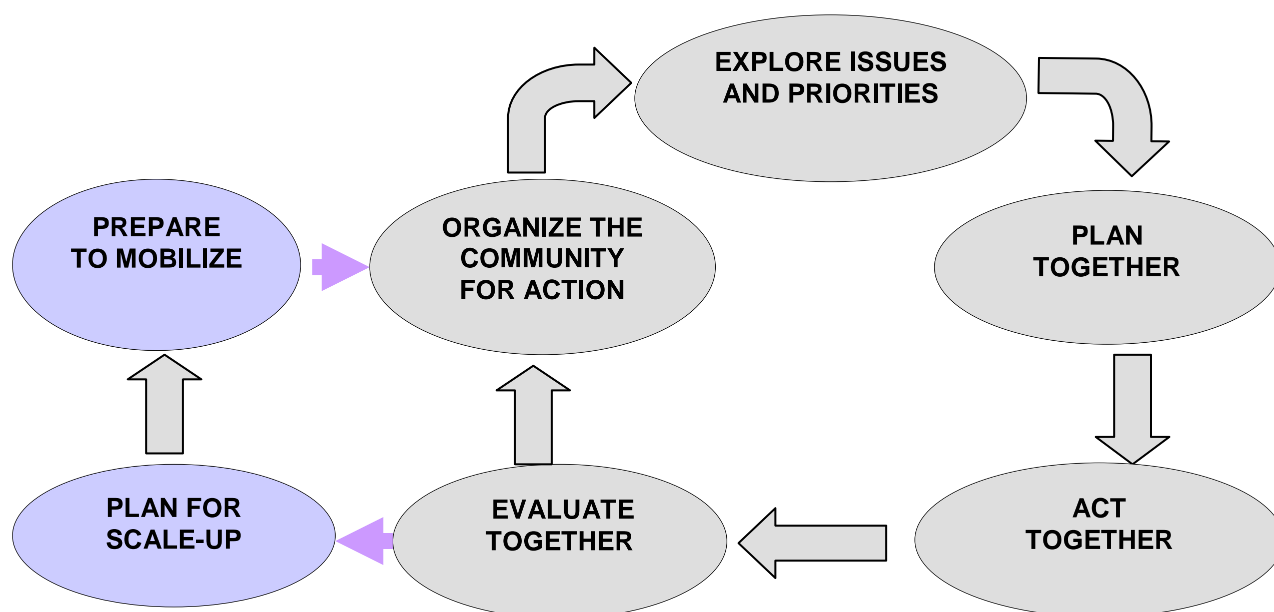
Specific CM objectives

- To empower PW and MWRA in particular and the community in general to make informed decisions regarding maternal and neonatal health care and family planning
- To help change social norms that result in or are related to harmful practices
- To strengthen the social-support networks/systems for pregnant women
- To increase collective efficacy to deal with obstetric emergencies
- To strengthen and/or develop community-based referral systems to increase the use of trained professionals/health workers and/or health facilities for antenatal and postnatal care and safe delivery.
- To increase the use of family planning by developing community-based referral systems and systems to ensure easy access and supply of FP services close to the home.

Community Mobilization and the CAC

How does MaMoni define Community Mobilization?
ACCESS, and now MaMoni, adopted the following definition of community mobilization*: "a capacity-building process through which community members, groups, or organizations, plan, carry out, and evaluate activities on a participatory and sustained basis, either on their own initiative or stimulated by others."*[1]

CM activities are summarized in the phases of what is known as the Community Action Cycle (CAC) (see Figure 2). The CAC is the common framework used for programming.



Where will the CM activities take place?

Selection of villages that will be targeted for CM activities will be done in consultation with local government counterparts (Union Parishad members), health workers and other active stakeholders in the Union and Upazilla. Decisions will be made based on pre-agreed criteria. In order to improve the integration of MaMoni components and allow efficient staff support of multiple program components, the project will seek to initiate CM activities in a subset of villages from the same Unions/wards selected for service strengthening. For example, if two wards within a Union are initially selected for service strengthening, staff will then consult with Union representatives on a subset of villages within the two wards to begin CM activities. Most likely, the project would not initiate CM in all villages within a ward due to resources constraints (human resources and time). The following criteria will guide village selection for CM:

[1] Howard-Grabman, L. and Snetro, G. How to Mobilize Communities for Health and Social Change, (Baltimore, MD: Health Communication Partnership/USAID, 2003), 3.

- Interest and willingness to participate
- Villages where PNGOs are working and have active groups
- Villages where religious leaders/social elites are ready to support the process
- Some villages with access to facilities and some without access to facilities
- Villages among those most disadvantaged / vulnerable ones (i.e. those that are not currently covered by NGOs, most remote or most difficult to access, where no services are available, with no current/past health interventions)
- Villages with comparatively high MN mortality rates and low contraceptive prevalence rates (since this data is not available at union or village levels this will be based on information provided by key persons/health staff)

It is important that some selected villages have proven capacity to get organized around common issues of concern, and be actively involved in activities/groups with PNGOs. These villages, when linked with less-organized communities through MaMoni efforts at the union level, will serve as examples to villages that do not have experience with collective action

Procedure for the selection of unions and villages
To prepare MaMoni start-up, Upazilla teams will conduct initial resource mapping (e.g. existing health facilities, governmental and non-governmental services, NGO programs, etc.). Based on results of mapping exercises, information obtained from key officials at the Upazilla level, and following the above-mentioned criteria, Upazilla teams will do a preliminary selection of unions in which to initiate MaMoni activities. The team will then conduct meetings in these unions with the Union Parishad Chairman and members, and health and FP staff. They will present the MaMoni project and get additional information for the wards and villages, such as,

- Inventory of NGOs and other services or programs
- Identification of gatekeepers and key persons to contact at the village level (to support CRP selection)
- Community-level organization/structures, formal and informal groups

As much as possible the CM component and service strengthening components will be rolled out together at a union level. This means that where a subset of unions within an Upazilla are selected to initiate service strengthening activities, this same subset of unions will service as the starting point for selection of villages (within these unions) that will initiate CM activities. The initial selection will include up to five villages from each selected union. As MaMoni enters new unions for service strengthening, the same process will be repeated for CM village selection. Villages within the new union will be prioritized according to agreed criteria, and a maximum of five villages in the new union will be invited to initiate CM activities.

Based on the results of these meetings, and positive/negative responses from communities that are invited to participate in CM activities, UTLs and FSs will do the final selection of CM targeted villages.

Who will facilitate the CACs?

The most significant change in the CM strategy is who has primary responsibility for facilitation of the CAC. During ACCESS, Community Mobilizers (CMs and CSMs) had primary responsibility for driving the CAC within villages. Although CM/CSMs worked closely with

Community Resource Persons (CRPs), all community meetings were facilitated or co-facilitated by them. Under MaMoni, Community Volunteers (CVs), two males and two females in each targeted village, will be responsible for facilitating the CAC. CVs will participate in a series of capacity building training workshops organized at the Union level to enable them to lead this process. FSs posted at the Upazilla level will provide additional mentoring support to CVs through monthly meetings held in a central location for all CVs of that union. FSs will also provide direct facilitation support during the community-wide action planning meeting.

How will CRPs' capacity to facilitate CM be developed?

CRPs will receive a total of seven days of Capacity Building Training (CBT) spread over a period of approximately four months (1st CBT -3 days; 2nd CBT – 2 days, occurs ~6 weeks after CBT1; 3rd CBT– 1 day, occurs ~ 2 months after CBT2). An outline of the content of each training workshop is attached as an **Annex.** Between each training workshop, CVs will be tasked with carrying out activities that they have just practiced during the workshop. After completing the CBT series, CRPs in each village will be able to support the CAC implementation.

Ongoing support for CRPs will be provided by FSs through monthly Union-level meetings and occasional visits to CVs as needed and requested by CVs. A JD and a brief workload analysis for the FS position are included as an **Annex.**

Lastly, MaMoni will seek to broaden its volunteer base by attracting existing cadres of community volunteers such as ***Ansars*** and **Village Defense Party members (VDPs)** to fulfill different roles according to their interests and availability (see section on who to involve and how). These cadres may also apply the skills they learn during CM training to their other responsibilities.

CVs will be recognized for their contribution to CM for MNH/FP during public meetings/events. An annual event to recognize and reward CVs will be organized at the Union level.

Elements to consider during CM

Duration of CAC and process documentation

Each targeted village will have developed its action plan approximately 4 months (months/10-12 weeks) after the CVs receive their first training. Completion of the first CAC will take approximately 6 to 7 months. The first cycle will constitute a learning period in which the CM approach and tools will be further adjusted to local contexts and needs.

Basic guidelines for CAC implementation

The following guidelines have been developed after individual meetings with project staff, observations during field visits in Sylhet.

Guideline	Rationale
Doable actions	People need and want to see results. Setting objectives that are attainable in a short period of time will build enthusiasm and empower people by strengthening their sense of collective efficacy (i.e. *"We can do it"*). For instance, the mapping of PW/MWRA can be done in a short period of time as part of the villages' action plans.
Focus on strengths versus deficits	The focus will be placed on strengths, positive attributes, and existing capacity in the villages. For instance, women's interest in their babies' *safety and wellbeing* will be at the center of CM activities. Also, existing local capacity at different levels (e.g. for planning, organizing, acting, etc.) will be identified and stimulated during the various CAC phases.

Based on people's experiences	Testimonials and real-life stories are powerful tools for reflection and action. ACCESS experience confirms it, and both PNGOs agreed on this point. Whenever possible, testimonials will be used as the start point of discussions and activities.
Participatory experiential learning	Related to the point above, the CAC will be built around actions and activities that facilitate participatory and experiential learning. This will require a *major shift* from traditional education/information sessions to participatory models of learning and (informal) education.
Entertaining activities	Villagers, and in particular women, have a heavy workload. They may be afraid of getting involved in activities that add yet another task to their schedules. Using existing socialization places/spaces and entertaining activities such as games will greatly facilitate their involvement and increase their interest in MaMoni.
Development of a common vision	Beyond the attainment of specific objectives, people will develop a common vision regarding MNH in their villages. Developing a common vision as well as solidarity around MNH will help develop local ownership of the project and assure long-term sustainability.
Focus on MNH	MaMoni will stay focused on MNH and FP. Staff and volunteers will have to be transparent about the project's scope and constraints while entering the villages as well as during discussions with government officials at central, Upazilla, and Union levels. To the extent possible, MaMoni staff will encourage communities to realize these activities by utilizing their own resources and by helping to link them whenever possible to other organizations that may assist with these other-sector activities.
Broad-based and inclusive	The findings, decisions and proposals for action by core groups (now named as problem identification groups) and Community Action Groups (CAGs) will be systematically shared with the broader community. Likewise, exchange mechanisms between and among villages will be developed for "horizontal networking" (i.e. among villages) and scale up.

Scaling-up strategy

As mentioned above, trained CVs will have facilitated the development of a community action plan within their village by approximately four months after their initial 3-day CBT. The first CAC will be completed within approximately six to seven months.

By the end of the 2nd month in each new Upazilla, the two FS teams (four FSs total) will be able to begin selection, training and field support of CVs in a 2nd two unions. This will allow for a total of 32 unions with CM activities initiated after six months of project start up in Habiganj (4 Unions each x 8 Upazillas).

According to the workload analysis, two FS teams can initiate work in 10 villages (one team per union, with CVs (20) from 5 selected villages within each union). Each FS team will then add a 2nd batch of five villages to their workload around the middle of the 2nd month. This will result in for total of ten villages per FS team or 20 villages per Upazilla. FSs should then have a period of one to two months during which they will not add new villages so that they can provide adequate support to trained CVs from the first four unions, allowing them to complete their cycle of action planning.

The total anticipated number of villages supported by October/November, 2010 is 160 (20 villages per Upazilla (8) in Habiganj). If the current plan and timeline proves realistic, the project can provide direct CM support to approximately 960 villages by September 2013. This is a somewhat optimistic scenario, in which CM activities would not be delayed by restricted access to remote working areas during rainy/ mud season or unforeseeable events, and CVs are enabled to carry out activities independently. The exact number of villages that can be covered should be reviewed in October 2010, after the first six months experience in Habigunj.

Additional villages (beyond the estimated 960) may also conduct CM activities through peer mentoring/coaching and other scaling up strategies such as village-to-village exchanges, the establishment of learning centers in "champion villages," as well as the development /strengthening of links with non-MaMoni supported organizations (which could, in turn, decide to include community-based MNH/FP action in their programs). It is expected that the model proposed by MaMoni will (naturally) expand towards neighboring villages through informal and formal networking, without always needing additional effort from project staff. The MaMoni team will also link program CVs with formal existing structures at the Union and Upazilla levels. For scaling up and sustainability to be most effective, it is important that program activities become integrated in and (to at least some extent) supported by structures that will remain after project support ends. For this reason the larger institutional home for the longer-term is proposed as the local government unit (Union Parishad). As previously stated, staff will work closely with Union Parishad members from the beginning to engage them in all aspects of the project, but most specifically to engage with CVs to support integration of local MNH/FP issues into union level plans.

Who will be involved in the different CAC phases and how?

1. Prepare to Mobilize: After their training, FSs will be ready to officially begin orientation meetings for unions members and other key stakeholders. During the union level orientation, FSs will gather names of existing community leaders and gatekeepers in the targeted (i.e. prioritized for CM) villages in order to orient village leaders to the project and gain permission to work within their village. This village level orientation will take place during an initial site visit by FSs (and possibly other MaMoni staff). Once FSs have permission from the community leaders to work with the village, FSs will facilitate a discussion to identify two men and two women who are interested and able to serve as CVs for their village. The FSs will explain the tasks and likely time involved to each prospective CV. FSs will also explain the purpose and goal of the project.

2. Organize the community for action and 3. Explore MNH and set priorities: In these first two phases of the CAC, the CVs will form or strengthen core groups (men's groups and women's groups or mixed groups). If existing groups meet the criteria for participation, then these groups can serve as core groups instead of forming new core groups. With the guidance of CVs (after CBT1), core groups will explore and prioritize MNH/FP issues in their village.

Composition and Functioning of Core Groups
CVs will establish women's groups, men's groups or mixed groups (core groups) in each village, either building on existing groups that fit project criteria, or organizing new groups. In most cases, the CVs will work separately with female and male participants respectively. The project team will need to consult with community leaders and CVs to assess whether working in mixed groups is feasible and determine whether working in mixed groups restricts women's or men's participation in the process. This decision will need to be made on a case by case basis.

The size of the core groups will likely average around 15 members. However, group size should remain flexible and depends on the CV's ability to work with larger groups. It is important that the core groups *represent those most affected* by the MNH/FP issues covered within the MaMoni

project, in particular: If there is high interest in participation and the number of interested participants exceeds the ability of the facilitator to manage that size group, the community may opt to have several core groups. This is especially practical if the village is large and covers a larger area. It is recommended that core groups meet at least bi-weekly initially.

FEMALE Core Groups	**MALE Core Groups**
- Pregnant women - Married women of reproductive age - The poorest of the poor (for example, VGD card holders)	- Their husbands
- TBAs , female *Ansars*, and (other) female leaders - Health and family planning (FP) staff	- Male *Ansars*, CVs - Health and family planning (FP) staff

Functioning of female and male core groups in the same village
Women's and men's core groups operating in a village will carry out the "organize" and "explore" phases separately. When they get to the step in the explore phase of gathering information on MNH and setting priorities, there are two options the CVs can propose to the groups:

Option 1:
The women's core group gathers information and analyzes it, and sets priorities by selecting 3 MNH problems to work on. At the same time, the men's core group gathers information and analyzes it and then sets priorities by selecting 3 MNH problems to work on. Both the women's and men's groups bring their respective priority problems to a joint community-wide action planning session. CVs will be the main facilitators of this planning session, supported by FSs. At the planning session, the two core groups present their priorities and negotiate to narrow down the six priorities to three or four. They then proceed to plan objectives, strategies and activities based on these three or four problems.

Option 2: (preferred process)
The women's core group gathers information from women and men, analyzes the information, and then sets priorities of 3 MNH/FP problems. The men's core group does the problem identification exercises and gives input into the women's core group information collection process. Men do not do the priority setting exercise but have input through the women's group. The women's group then brings its priority problems to the community-wide planning session which is attended by men, elders, and others who can provide support to planning and implementing collective action.

The second option is preferred because it is more likely to ensure that the most vulnerable women's voices are heard when setting the agenda for planning.

4. Plan Together: FSs will provide co-facilitation support to CVs during the action planning session (immediately after CBT2). In this community-wide action planning session the core group members and CVs may decide to form a coordinating body which will coordinate and monitor the action plan activities. MaMoni refers to this group as the Community Action Group (CAG). The CAG may consist solely of core group members, but is more likely to involve a combination of core group members and other community leaders and elites. The villagers will decide what the composition of this group will be and what they would like to call it.

5. Act Together and 6. Evaluate Together: Once the action plan is developed, tasks and responsibilities divided, and CAG formed, the CAGs will probably need to meet less frequently (once a month). When motivated and focused on the achievement of common, concrete goals and objectives, the CAGs will probably meet more often and as needed. They should also be active

during (unforeseeable) emergencies. Core groups may continue to meet after the CAG has been formed, if they choose to do so, and/or if requested by CAGs for consultation on the progress, evaluation, and further revisions of the action plan.

Who (else) should be involved in the CM process/different CAC phases?
Not everyone has to participate at the same level or with the same intensity in each phase of the Community Action Cycle (CAC). While some or all core group members and CVs will become members of CAGs, other villagers will be encouraged to join the CAC in other ways and during different CAC phases.

The following list of "who to involve" is based on ACCESS' experience. It includes MaMoni's primary "target groups" (PG, MWR) followed by "key influentials" regarding MN/FP practices.

PW/MWRA & family members	**Key village members/groups**	**Governmental facilities**
- Pregnant Women (PW) - Married women of reproductive age (MWRA) - Shasuri (mother in law) - PW's mother - Husbands - Shashur (father in law) - Nonod (sister in law) and jal (brother in law's wife)	- TBA - Traditional and/or religious leaders - UP chairman and members - Madrashas' teachers - Village doctors - Herbal doctors - Drug sellers - Local elites (e.g. *matbor:* social mediator/arbitrator) - Formal authorities - *Ansars* and VDPs - Community Clinic Management Groups members (CCMG). - Credit groups - (Youth) clubs	- Health and FP staff: FWV, FWA, HA

The following *illustrative examples* of how to involve these persons/groups are based on field observations, input from the Intervention Design Community Mobilization Workshop participants, and the review of pertinent documentation:

Who	**How**
Pregnant Women (PW) & Married Women of Reproductive Age (MWRA)	Should be involved in core groups and CAGs and be called upon to participate in the various CAC phases. Core group and CAG discussions could be organized with them in places where they usually meet. For instance, some young women (including MWRA) meet regularly in production units run by FIVDB, where they socialize and talk about their daily concerns. Core groups could build on these groups by proposing topics that are of particular interest to women.
TBAs	Could also become CVs. They can play a key role during community mappings of PW and MWRAs. They should be invited to participate in the development of emergency transport/financial systems and in collective actions to facilitate the (timely) referral of women and newborns to health professionals/facilities when needed.
Imams	They can provide information on satellite clinics and talk about the importance of MNH especially before Friday's Prayer. Imams/religious leaders should be invited to actively participate in CM activities, including the identification of MNH/FP needs and problems. They can be called upon to identify passages of the *Quran* that can effectively support the key MNH/FP behavior changes promoted by MaMoni.
Formal community	(Such as UP male and female members) should participate in the Union orientation meeting, and in the development of the Community Action Plan, facilitate the implementation of activities, and take part

leaders	in the evaluation of the village action plan. Male/female UP members should be encouraged to participate in CAGs as appropriate and feasible. They should be involved in community-based advocacy.
Husbands and shashur of PW/MWRA	Could become members of the core groups and/or CAGs. They can play a key role in the establishment of emergency transport/financial systems. Some CM activities could be organized in (informal gathering) places frequented by men, such as tea stalls, to facilitate/encourage their participation.
FWV, FWA, HA	Public health staff should be represented in the CAGs wherever possible and participate in the various CAC phases.

A general table of who is involved in each phase of the CAC follows.

PHASE	**MAIN ACTORS INVOVLED**
Organize the Community for Action	
• Community entry	Union Parishad Chairman and members, identified community leaders and gatekeepers, FSs
• Core group formation	CVs lead with participation from MWRA and their husbands from most vulnerable families TBA, HA, FWA
Explore MNH/FP and set priorities	
• Identify MNH/FP problems	CVs, Core group members (men and women), HA, FWA
• Gather information from broader community, analyze it and set priorities	Core group members (women and men (see discussion on core group formation for options for this phase), CVs
Plan Together	Core group members (men and women), community leaders, health providers including TBA, HA, FWA, Village Doctors and other stakeholders from the broader community. FSs (a team of one male and one female, if possible) provide facilitation support during the community-wide action planning meeting in which the CVs/core groups share with the larger community the prioritized MNH/FP issues and proposed solutions, develop an action plan and form a coordinating group (Community Action Group (CAG)).
Act Together	As determined in Community Action Plan, CVs, HAs, FWAs, Union Parishad members, FS
Evaluate Together	Representatives of CAG, core groups, HAs, FWAs, CCMG members, Union Parishad members, possible external participation of local NGOs, neighboring villages that would like to learn about the process, and/or others.
Prepare to Scale-up	FSs, depending on experience and interest- representatives from CAG including core group members and other CVs

Linkages between CM and BCC components
The CM and BCC components should be articulated in such a way that they reinforce each other. BCC materials can feed or complement CM activities and vice versa. For instance, printed, audio/visual materials or theatre/video tours can support group discussions/community events/fairs on MNH/FP that villagers may want to organize. Additionally, issues and perspectives raised by community groups in relation to attitudes, beliefs and practices as well as locally acceptable and feasible ways to improve MNH/FP can feed into the development of BCC methods and materials, giving community members an opportunity to participate in the development of these methods and materials.

Integration of Service strengthening and CM components
The issues discussed within CM activities will be consistent with those raised by HAs/FWAs at the household level. As far as possible, HAs/FWAs will participate in *key* community meetings, especially the action planning session. During this meeting CVs will explore with the community how they can collectively assist HAs/FWAs to identify and support pregnant women quickly and systematically so that more of the HAs/FWAs time will be freed up to provide services.

Monitoring and evaluation

Participatory monitoring and evaluation
CVs/CAGs will coordinate and oversee participatory M&E and share the results with the broader community. They will collectively identify M&E criteria/indicators, who wants/needs to participate in M&E, and define how they will collect and analyze the information during the development of the community action plan. Sharing the results of participatory evaluations with the broader community is an opportunity for *celebration* and *recognition* of individual contributions (e.g. committed CVs) and collective achievements (e.g. establishment of a village-based emergency system). Likewise, villagers will be encouraged to share their successes and lessons learned with other communities to “spread” CM for MNH/FP improvement in the surrounding areas.

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CM indicators in the baseline and endline surveys
As part of resource mapping during Union/community entry, the project team will collect baseline information on the following indicators:

- Number of groups organized working on MNH issues
- #/% of Union Parishads that have taken action to improve MNH status and/or address MNH/FP issues (as indicated in the Union's annual plan).
- #/% of Union Parishads that have used local government resources to address MNH/FP issues (and amount).

CM indicators for ongoing monitoring of community capacity
The following indicators are suggested to monitor the developing capacity of participating communities. This list has been shortened compared to the indicators tracked under ACCESS. Progress on these indicators will be monitored by FSs through regular review of simple registers

- #/% of Union orientation trainings on CM conducted in project area
- #/% of CVs trained in the project area (disaggregated by gender)
- #/% of Unions with CV Committees that meet regularly (at least once every two months)
- #/% participating communities with Action Plan
- #/% of participating communities with Action Plans that have completed more than half of their planned activities within 12 months.
- #/% of communities with Action Plans that have achieved at least one of their desired results as specified in their Action Plans within 12 months.
- #/% of Community Action Groups (coordinating group formed during the planning session) that met at least once in the last two months.
- #/% of participating communities with functioning monitoring system to track pregnancies and births in the community.