CULTURE FOR CHANGE

Inspiring life in frozen communities

Resource Mapping & Mobilization: A Reference Guide

Contents

1. Introduction

1.1 Inspiring life in frozen communities

Culture 4 Change (C4C) works on a combination of a deep understanding of stories: cultural norms, values and beliefs from different places and different people. We combine this with a shared understanding of the impact of climate, warfare and poverty. Based on these two pillars we help bring change – together, we create new stories, big or small.

We do this in different ways. One way is by addressing collective trauma. People who cannot fight or flee become paralysed or frozen.

We have seen in many places how communities or groups have given up any hope of improvement. By discovering together what is still possible, what resources are still available, and how we can connect to new information, we always come up with surprising results. We activate frozen communities. By beginning to move again, new forms of cooperation emerge, new sources of income are found, and new stories emerge.

Resource Mapping & Mobilization

Resource Mapping & Mobilization (RMM) is an approach that has been developed by the co-founders of C4C between 2004 and 2016 based on their experiences when working in and with communities in fragile states to improve their overall health, wellbeing, and resilience an while adressing the social determinants of health and wellbeing; the social conditions that we are born into that affect our individual and collective functioning. These are powerful forces in any context, but in fragile states, they are particularly salient: institutional, political and legal systems designed to protect and support people malfunction or have disappeared. Frequently, conflict causes damage to the (health) infrastructure and destruction of economic capital, resulting in an increase in poverty. On a deeper level, the social fabric of the community is often destroyed; families are scattered, and community members mistrust each other. Throughout its history of implementing health interventions in such contexts, the co-founders of C4C have learned that these issues must be actively addressed, if we are to have a lasting effect on the wellbeing of individuals and communities.

Community mobilization is at the heart of the RMM approach. This is the process which facilitates the active participation of community members in achieving a collective goal, without being dependent on external or more powerful figures. The goal is to improve the health and wellbeing of community members; however, the mobilization process focuses on the *social functioning* of the community as a whole. Existing community structures are reinforced, and new ones are built to create social ties on multiple levels. Psychosocial support is also provided to build the resilience and capacity of individuals involved in these structures. This aims to create an environment where community members can take control of their own wellbeing and become fully involved in problem-solving and public service delivery. This is the foundation for developing more specific interventions and connecting to specialized services. Depending of the needs of the particular community, this foundation can develop in any number of directions: for example, towards (sexual & reproductive) health care, education, or livelihoods development.

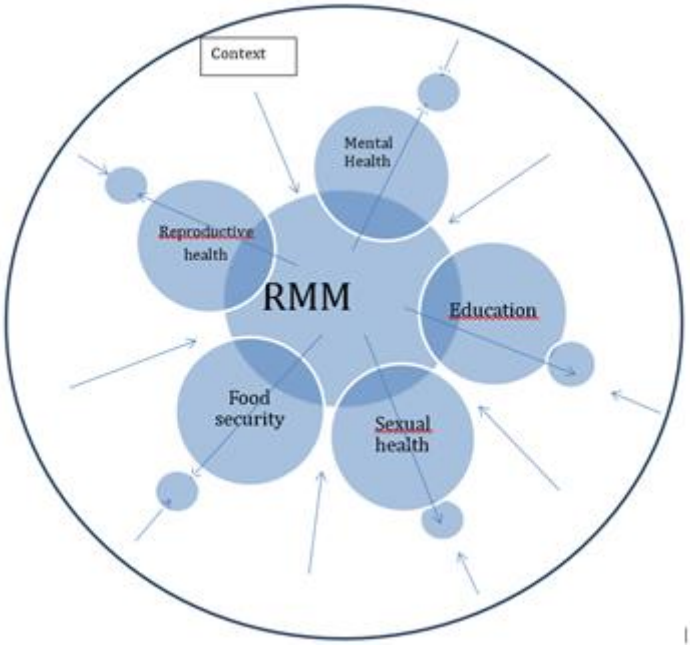

Figure 1: RMM as a foundation for improving health and wellbeing. The central circle is the RMM programme, which *overlaps* (see shaded areas) with community-based services and interventions in various domains; examples of which are given in the mid-sized circles. RMM reaches out to more specialized, institutionalized services (hospitals, schools, public services) through community-driven action. The RMM approach and the various services are all embedded in the wider context of a post conflict or disaster-affected state. The context will interact with the RMM process, both directly (creating the social conditions of the approach) and via the institutionalized services (defining how the infrastructure of the affected community works).

1.2 Resource Mapping & Mobilization in practice

Photo 1: Women's group income-generation; Nangarhar province Afghanistan

Women's empowerment in Afghanistan

The RMM approach was derived from the Global Fund framework for improving health through community systems and has been developed and adapted by the co-founders of C4C over the last years. It was initially implemented in Afghanistan, where it has been a major component of our work with conflict-affected groups of women. The approach has been used to build the capacity of these groups in 10 participating provinces between 2004 and 2014 and has resulted in the establishment of self-organized income-generating activities and tailor-made services for thousands of vulnerable women and children.

Rehabilitation of communities in Burundi, South Sudan and Congo

Since 2011, the approach has also been implemented in the context of the Dutch Consortium for Rehabilitation's (DCR) 'Pamoja' project[1], in which the co-founders of C4C were key players. The consortium aimed to rebuild the infrastructure of post conflict zones in the African countries of South Sudan, Congo and Burundi. Burundi has provided the most recent and fruitful data on the functioning of the approach, and is the setting for large-scale interventions, in which RMM is the core strategy.

RMM for Sexual and Reproductive Health Rights

The approach has been further developed in 2013 when the co-founders of C4C begun implementing a large scale, multi-layered Sexual Reproductive Health and Rights (SRHR) programme in Burundi, funded by the Dutch Embassy of Bujumbura. Within this programme, i) family planning, ii) the use of sexual and reproductive health services by youth and iii) a support/care system for survivors of SHRH violations, are jointly addressed. At the beginning of this project a process evaluation was carried out (see Annex 2 of this document) in order to find out if the proposed approach would be an adequate approach for this specific project. Our research and experiences of RMM since its inception have convinced us that it is a vital element of complex health-related interventions such as this one. RMM was therefore used as the central strategy within the SRHR programme; for example, through connecting National level family planning programs with civil society groups (via the networks) to expand the access to family planning commodities and services. A Mid-term evaluation of this specific project, conducted in November/December 2014, permitted to evaluate results so far and resulted in the formulation of a set of recommendations that have been integrated in this document.

1.3 A guide to RMM and its implementation

The following sections of this guide describe and reflect on the community mobilization process within RMM, mainly as implemented through the SRHR program In Burundi. Together, they form a reference tool for RMM, explaining concepts behind the approach and providing a protocol for its application.

The first section provides a **glossary of key terms**, as defined by the co-founders of Culture 4 Change, in relation to RMM. These terms feature heavily throughout the rest of the guide and introduce the main concepts that underpin the RMM process. RMM is then placed in the context of wider literature and research into similar community-based interventions, with a **review of**

[1] Dutch Consortium for Reconciliation: http://dcr-africa.org/en/

evidence and approaches to community mobilization for promoting wellbeing. This is followed by a brief description of **4 landmark theories** that have informed and influenced the development of the RMM approach. Next, a **conceptual model** of the RMM process is presented using a visual method of mapping interventions and their pathways to change. Before reading the largest section of the guide- the RMM Protocol- it is important to note the 'Initial Considerations', which flag up key obstacles and ethical issues that are likely to arise when implementing any RMM programme in a post-disaster or fragile state. The **protocol** provides a guide to implementing the 7 essential components of RMM, incorporating the lessons learnt and best practices of all C4C related initiatives. Finally, a **guide to conducting a Process Evaluation** of the RMM model provided, including an interview schedule and the main findings of a study conducted in Burundi in 2013.

This guide can be used by all NGO staff involved in the design, coordination, implementation and monitoring and evaluation of projects that (aim to) use RMM as a key approach to achieve their goals. Users of the guide are encouraged to apply the approach to a broad range of projects and interventions that aim to improve the health and wellbeing of conflict or disaster-affected communities through community mobilization.

2. Glossary of relevant concepts

Community

A community can be described as a group of people that recognize themselves or is recognised by outsiders as sharing common cultural and/or religious features, backgrounds and interests that form a collective identity with shared goals. What is externally perceived as a community might in fact be an entity with many sub-groups or communities. It might be divided into clans or castes or by social class, language or religion. A community can be inclusive and protective of its members; but it might also be socially controlling, making it difficult for sub-groups, particularly minorities and marginalised groups, to express their opinions and claim their rights[2]. A community can be a village but also a district or neighbourhood in a town, in other words; communities are diverse and dynamic.

Community systems

Community systems are 'community-led structures and mechanisms used by communities through which community members and community-based organisations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities'[3]. The community systems can be small and/or informal or more extensive with for instance sub-systems or a network system between several organizations, which can include health care, advocacy and other support systems. It includes many civil society organisations, such as Community Based Organisations (CBOs), faith-based organisations (FBOs), NGOs, groups and individuals or networks or associations of people that work with or in a specific community.

Well-being

Well-being is a good or satisfactory condition of existence; a state characterised by health, happiness, and prosperity. Well-being should not be confused with the concept of standard of living, which is based primarily on income. Instead, standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging, while taking into account the importance of family life and the spiritual, cultural and ecological dimensions of well/being (see also definition *health*).

Health

We have adopted an elaborated version of the WHO definition of health, formulated by Somasundaram and Sivayokan (2013, p.5) which uses the multi-level concepts of Bronfenbrenner's ecological model (see p. 21 of this guide for details of this model). This also emphasizes the need to look beyond the micro or individual/physical level of health, but makes further additions- in parentheses- to the initial definition:

"Health is a state of complete physical, mental, (familial), social, (cultural), (spiritual) and (ecological) well-being, and not merely an absence of disease or infirmity."

The family unit has been included as it is paramount in many societies where we as Culture 4 Change are active and where a spiritual dimension is an essential part of culture. The spiritual dimension

[2] UNHCR, 2008; pg. 15.
[3] The Global Fund (2010). *Community Systems Strengthening Framework.* http://www.theglobalfund.org/documents/civilsociety/RMM_Framework.pdf, page 31.

has been put forward at various WHO fora but has not been formally accepted yet. Culture is increasingly recognized as an important dimension of mental health. The ecological dimension arises from Bronfenbrenner's overall holistic approach, looking at how the different levels, dimensions and systems with different temporal trajectories of their own influence each other to produce an interactive, dynamic (dys)functional whole.'

Sexual Health

A state of physical, emotional, mental and social well-being related to sexuality: not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled[4].

Reproductive Health

A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes[5]. Reproductive health therefore implies that people are able to have a satisfying and safe sex life. They must also have the capability to reproduce, and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice. Finally, this includes the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant[6].

Social determinants of health

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. The social determinants of health include income, food security, social or cultural connectedness and status, education, employment and working conditions, gender, social support, policy, and legal and governance issues[7] .

Mental health versus mental disorders

Mental *health* is defined as*:* "A state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"[8].

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[4] WHO Draft Working Definition, October 2002
http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf
[5] The Lancet Sexual and Reproductive Health Series, October 2006.
http://www.who.int/reproductivehealth/publications/general/lancet_1.pdf
[6] UN Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994, Para 7.2a
[7] Commission on Social Determinants of Health, 2008, WHO
http://www.who.int/social_determinants/thecommission/finalreport/en/index.html
[8]WHO Comprehensive mental health action plan 2013–2020 http://www.who.int/mental_health/en/

A mental *disorder* is a psychological pattern, potentially reflected in behaviour, that is generally associated with distress or disability, and which is not considered part of normal development of a person's culture. Mental disorders are generally defined by a combination of how a person feels, acts, thinks or perceives. The recognition and understanding of mental health conditions has changed over time and across cultures, and there are still variations in definition, assessment and classification, although a standard guideline criteria is widely used[9].

Psychosocial interventions

The term psychosocial is used to underscore the close and dynamic connection between the psychological and the social realms of human experience. Psychological aspects are those that affect thoughts, emotions, behaviour, memory, learning ability, perceptions and understanding (micro level). Social aspects refer to the effects on relationships, family and community (meso level), extending to traditions, religion, culture and values and the economic and political realm and its effects on status and social networks (macro level). The term is also intended to warn against focusing narrowly on specific mental health concepts (e.g., psychological trauma) at the risk of ignoring aspects of the social context that are vital to well-being. The emphasis on psychosocial also aims to ensure that family and community are fully integrated in assessing needs and interventions.

1.1 [9] **Diagnostic and Statistical Manual of Mental Disorders *published by the APA: DSM-5).***

3. Literature Review

3.1 Introduction

Community mobilization (CM) is an approach within community development that focuses on empowerment and social participation. It is a key strategy to promote the wellbeing of marginalized or disadvantaged communities and has been adopted as the overarching approach within RMM. The conceptual model of RMM, outlined in the fifth section of this guide was developed in the context of a paradigm-shift in approaches and theories of health promotion over the last two decades. The focus has moved from the individual health status to functioning of the social environments, and this is reflected in the academic literature in the social sciences. The prolific growth of theories of Social Capital in this period indicates that wellbeing is something that depends on collective as well as individual processes. We felt there was a need to examine these applied and academic trends as a unified body of work, in order to answer questions about how CM operates, its effects on individual *and* collective wellbeing, and the mechanisms that link these three concepts. This, in turn, would place the RMM model in its wider context and inform our own theory-based research into its effects on health and wellbeing in fragile states.

CM is part of the community development model that, over the last two decades, has grown to be a vital addition the biomedical and behavioural paradigms in global health and wellbeing promotion (Beeker, Guenther-Grey and Raj, 1998). This has occurred largely in response to the realization that interventions that focus solely on technological 'fixes' from external sources are often culturally irrelevant, result in only short-term gains or generate cycles of dependency (Campbell and Jovchelovitch, 2000). There is no single, predefined model for the approach, and it has been appropriated in various ways across different domains. Broadly speaking, CM is the process of empowering communities to achieve goals in a participatory and functional way. Perhaps the most prominent example of CM is in the field of health promotion in HIV/AIDS management, where participatory methods have slowly taken over traditional sexual health education. The Global Fund encompass Malaria and TB as well as AIDS in their Community Systems Strengthening (CSS) framework (Global Fund, 2011), which is based on the CM approach. This provided the starting point for the RMM model that defines the context of C4C's work.

A review of the literature in 2012/2013 This review focused on the use of CM to promote 'wellbeing' in its broadest sense, returning to the Alma Ata declaration of 1978, which defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This broad conception of wellbeing is pertinent to the domain of international development as it highlights the multi-dimensional nature of poverty and its impacts, incorporates the holistic view of health that is advocated within global health promotion and considers the psychosocial elements of wellbeing that are affected by war and conflict (Wessels and Bretherton, 2000). This literature search therefore focused on wellbeing within this domain. More specifically, it considered wellbeing in areas of national economic disadvantage (Low- and Middle-Income Countries, or, LAMICs) and in post-conflict zones, where the disadvantage is bound to social and political factors. It also considered communities in high income or stable countries that nevertheless experience high levels of poverty due to social exclusion.

There have been some literature reviews of CM (and its effectiveness) in the context of health promotion, all of which suggest that the evidence-base for its efficacy for improving health is thin. This is largely because CM cannot be evaluated in the same way as other less complex and more focused health interventions. Direct health outcomes cannot be predicted and measured based on this approach, because problems and solutions are not predefined. This means another paradigm (of studying processes rather than direct outcomes) must be adopted to understand the function of these approaches. We have to understand the *mechanisms* in these interventions to evaluate them (Wind and Komproe, 2012); this is something that is not generally done in the current literature, according to available reviews.

Laverack (2006) conducted a review on improving health through community empowerment in its broadest sense. However, community participation features only briefly, and although it reports studies suggesting that it is beneficial to health, no methodology was reported, or analysis of quality carried out. Evans, Pilkington and McEachran (2010) conducted a systematic review on all participatory approaches in UK public health units (for marginalized populations); the conclusion was that CM seemed positive for health but that there was scarcely any evidence available to verify this. The most recent and relevant review (in terms of context) was carried out by McCoy et al. (2011) on Health Facility Committees (HFCs) in improving public health in LAMICs. They found a substantial body of literature to help them build a conceptual model of the key features and processes involved in HFCs but only 4 evaluation studies. Although these all reported beneficial effects, they relate more to the functioning and outputs of the health service than the wellbeing of the community and were also considered to lack external validity. Finally, in a conceptual review, Rifkin (2009) looks back at the progress of community participation since the Alma Ata declaration. She observes that investigation into "what works, why and how" in these approaches has been seriously limited over the years.

As well shedding little light on the effectiveness of CM, these reviews relate only to outcomes on the first level of wellbeing; that of individual physical health. Given the broad conception of wellbeing that has been established here, the review in 2012/2013 seek to depart from the health system context and explore a full range of CM models and their effects on individuals and groups. The three specific aims are: 1) to review the different conceptual models of CM in low-income settings, marginalized communities, and post conflict zones 2) to review the evidence base for the effects of CM approaches on individual and collective wellbeing and 3) to reflect on the RMM approach in its theoretical context, making explicit the underlying concepts that informed it development.

3.2 Methods

Three databases were searched (Pubmed, PsychInfo and Jstor) for publications that included terms relating to community mobilization and individual or collective forms of wellbeing in their titles or abstracts. Specifically, the search term was: ("community mobiliz*" OR "community mobilis*" OR "community participat*" OR "community development") AND ("well-being" or "social capital"). The search was conducted in May 2012.
The inclusion and exclusion criteria were as follows: All peer reviewed articles and published book chapters were included but dissertations and book reviews were excluded. Papers were included if its population was from a Low And Middle Income Country (LAMIC, according to the

World Bank, 2007)[10], or a post conflict zone, or a marginalized community within a higher income state (for example refugee communities). If the paper reported an intervention, this had to target the community as a whole: interventions focused on individuals were excluded. Outcome measures included all elements of wellbeing (physical/ mental health, psychosocial wellbeing, group level social cohesion/ social capital). Theoretical discussions and models of community participation or mobilization were also included.

Before papers were read in full, the reliability of the inclusion criteria was tested by comparing the judgments of the primary reviewer and a supervisor for 10% of the total list of results. Cohen's Kappa was applied the data and produced a value of .76 (SD= .16). This is considered to be "good" agreement (Fleiss, 1981).

3.3 Results

The search terms produced a total of 191 publications: Psychinfo, 138; Pubmed, 50; Jstor, 3. After the removal of duplicates and application of the inclusion/ exclusion criteria, 24 were reviewed in full. Because there are a wide range of different publication types within this data set, they are categorized into one of 4 broad types. There were 6 Theoretical Papers, 5 Intervention Models (with no evaluation), 6 Empirical studies (with no intervention) and 7 Empirical Intervention Evaluations (where an intervention is defined and evaluated empirically).

The majority of studies (16/ 24) focus on LAMICs or post conflict zones, including 11 different countries (Papua New Guinea, South Africa, India, The Ivory Coast, China, Malaysia, Northern Ireland, Ethiopia, Bolivia Zambia and Sri Lanka), whilst 8 studies make marginalized communities within high income settings (UK, Australia, Canada and the US) the object of their research.

[10] World Bank (2007). Data and statistics, http://web.worldbank.org/ (Accessed May 2012).

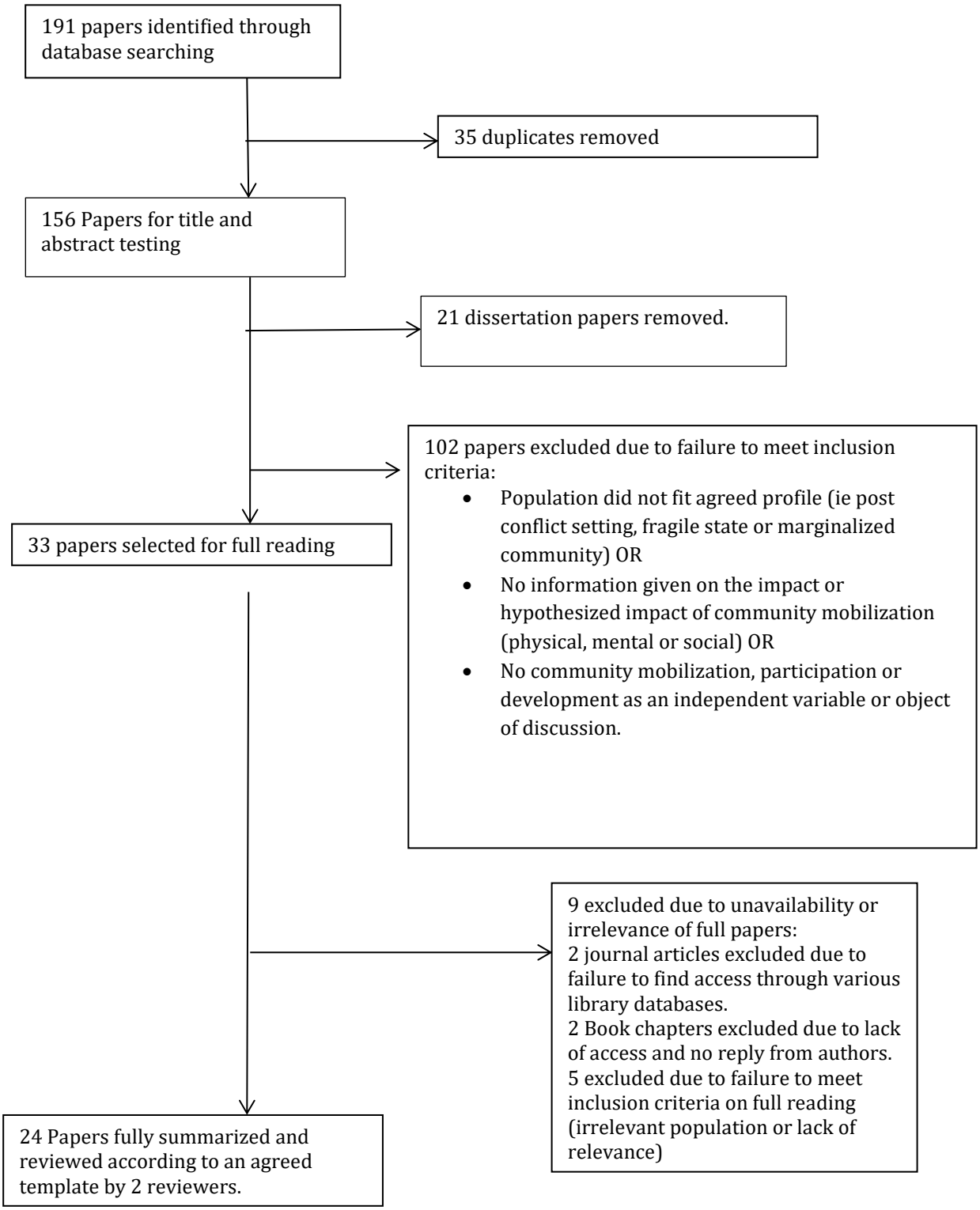


Figure 2: Flow chart depicting the selection process of literature.

3.4 Theoretical considerations and concepts

CM is operationalized in terms of

1. *The conditions required for community action:* In the literature this is framed as a 'make or break' factor in CM interventions: if the conditions support CM activities (e.g. advocacy from authorities), interventions will thrive but if the conditions are problematic (e.g. dominance or exclusion of certain social groups) this can render community action impossible.
2. *The process of empowerment:* The majority of publications (20 out of the 25) at least mention the concept of empowerment as a key mechanism in CM interventions. This can be seen as either a process or an outcome of CM interventions, but is generally presented as a process or mechanism in the literature, as none attempt to measure it as an outcome.
3. *The successful management of resources:* The identification and mobilization of existing community resources is widely recognized in the literature to be important for making CM a reality. Chau-kiu Cheung and Wing-chung Ho (2012) go a step further and posit that community participation is only rewarding for individuals if they are able to invest resources into the community.

Wellbeing is operationalized on individual and collective levels

1) *Individual* level wellbeing focuses on physical or mental health improvements and individual empowerment in order to engage in healthy behaviours. Therefore, those interventions focused on specific health outcomes can be seen to consider individual (as well as collective) wellbeing as a result of CM interventions

2) *Collective wellbeing* is the social functioning and overall resilience of a community; the subsequent improvement of individual health is secondary to this social outcome. Several of the intervention models primarily focus on building positive social or community networks but (with the exception of Griffiths et al., 2009) this is not measured systematically. Moreover, the relationship between this collective wellbeing and individual wellbeing is only fully explored in theoretical papers (see below)

Social Capital

The dominant theory in the literature is that of Social Capital (in its various forms), which is clustered in papers published between 2005 and 2012. There is some experimental evidence about the way this operates but it is generally not integrated directly into the intervention models or evaluations. This reflects the observation by Campbell and Jovchelovitch (2000), that there is a lack of communication between practical development work and theory about social participation.

The concept of Social Capital is most often used with reference to Putnam's (1993; 1995) theory, which posits that the social ties within and between community groups, provide the social cohesion for a society to function effectively as a whole and benefit the individuals involved. Social Capital is described as "the glue that holds a society together" and manifests itself in the amount of participatory potential, civic orientation and trust available to others in a society. It is therefore

focused on large social units and is dependent on collective (often material) resources. SC can be broken down into more complex dimensions or types:

- *Cognitive Social Capital* is about how people *think and feel* about their social relations
- *Structural Social Capital* is how they *behave* and the community structures that result from this behaviour.
- *Bonding Social Capital* refers to the ties *within* existing community networks
- *Bridging Social Capital* is the linkages made *across* different groups or networks.

Other authors (Bain and Hicks, 1998; cited by Thomas, 2006) reference a further breakdown of these dimensions to:

- *Cognitive Social Capital i*s about how people *think and feel* about their social relations
- *Structural Social Capital* is how they *behave* and the community structures that result from this behaviour.

The general concept is explicitly referenced in 7 of the 24 publications and all except 2 (Palmer et al., 2011; Chau-kiu Cheung and Wing-chung Ho, 2012; which are unconnected to the domain of health) link SC directly to physical or mental health- although not all demonstrate this empirically. The common hypothesis in this formulation is that improved Social Capital on a collective level can have a direct positive effect on health at an individual level.

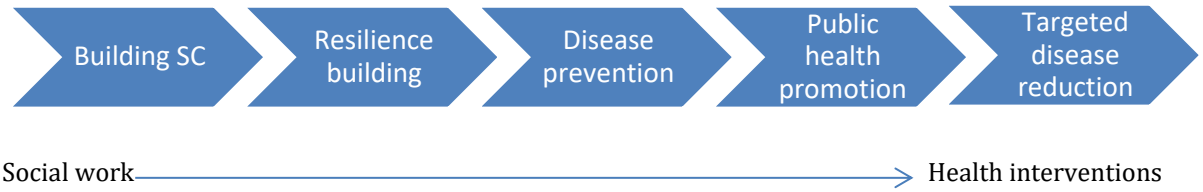
3 of the 24 publications also mention the earlier formulation of Social Capital, established by Bourdieu (1986), which is understood as a more critical theory about the way in which social relationships create power and the ability to control resources (Wakefield and Poland, 2005). It is less clear about the direct outcome of building this Social Capital and is therefore rarely used in the context of applied public health interventions. It focuses instead on the *potential of* persons, families or communities to control their environment when they belong to strong networks and social structures.

Theoretically, Social Capital is thought to improve wellbeing by:

1) *Facilitating community self-help* so members can work together to solve collective health problems (Wakefield and Poland, 2005). On a social psychological level "collective social identities" (created by community participation) can determine healthy behaviours (Campbell and Jovchelovitch, 2000).
2) As a *bidirectional process for individuals***:** poor health and mental health affects social functioning and good social support from community networks promote healthy behaviours and access to care (Griffiths et al., 2007; 9). As such, it is important to ensure that the social components are part of a wider programme of health promotion, so that people have the physical and mental health to set this positive cycle in motion.

3.5 Concrete Interventions

There are 12 'concrete interventions' described in the set of reviewed literature. A concrete intervention is defined by a clearly planned and implemented activity, which focuses on community participation or mobilization and is described in the reviewed paper. Although all are based on participatory approaches, the *content* of interventions varied vastly. The intervention models can be placed along a spectrum according to how directly health-related they are:



The majority of interventions had the objective of promoting health and used participatory methods to guide their activities. Specifically, 5 focused on overall public health (Ashwell and Barclay, 2009; Heenan, 2004; Lardon, Soule, Kernak, and Lupie, 2011; Rios, Olmedo and Fernandez, 2007; Tribe, 2004), 2 focused on AIDS/HIV management (Campbell and Mzaidume, 2001; Swendeman et al., 2009), 1 on the prevention of dengue fever (Crabtree, Wong and Mas'ud, 2001) and 1 on psychosocial wellbeing in a humanitarian crisis (Carr, 2006). The 3 that do not focus directly on health promotion in their approaches (Griffiths et al., 2009; Pence, 1999; Tsey, et al. 2002) aimed to build SC with community activities, create a child-care education programme and practice action research (PAR) within a men's group, respectively. However, all had a longer term goal of improving health or wellbeing and believed their interventions to be an intermediate step towards this. This is consistent with the idea that SC is a mediating factor between community participation and health.

3.6 Evaluations

7 of the 12 publications that describe 'concrete interventions' evaluate their activities empirically and systematically. These evaluation papers are summarized in the table below:

Author(s) and date	**Sample size**	**Intervention (and aim)**	**Methods**	**Intervention effects: Social or group level outcomes**	**Intervention Effects: Individual health/ wellbeing outcomes**
Ashwell & Barclay (2009)	N= 175	Community Action Participation Programme (CAP) and Village Health Volunteer (VHV) training to improve public health	Mixed method, single time-point outcome evaluation. Qualitative interviews and FGDs Checklist tool for healthy communities	Positive interaction between the community and rural health workers.	Increased knowledge and understanding of the 'real' (root) cause of illness. Reduced incidence of illness and improved physical health of those villagers who made behavioural and environment changes Women no longer dying in childbirth. (statistically unverified)
Campbell & Mzaidume (2001)	N=30	Participatory Peer Education programme for sexual health promotion.	Micro qualitative case study In-depth interviews	Some community dynamics (e.g. jealousy and hostility to paid peer educators, punishment and surveillance of non-condom users.) changed for the worse ('anti-social capital')	Increased confidence of peer educators and *some* sex workers. Too early to measure sexual health outcomes
Crabtree, Wong & Mas'ud, (2001)	Not reported	Participatory Action Research (PAR) to reduce Dengue fever.	Participatory Action Research (PAR) 3 time points (including baseline) Qualitative (FGDs) and quantitative (Dengue mosquito %) evaluations	Wider community participation after the PAR study. Strengthened community networks, enabling communities to advocate with government departments. Enhanced appearance of the kampungs (villages), demonstrating a sense of civic pride and a commitment.	A reduction in Dengue-bearing mosquitos. (Actual incidences of Dengue fever not measured)
Griffiths, Horsfall, Moore, Lane, Kroon & Langdon (2009)	Baseline survey: N= 327 Follow-up survey: N=328	Community initiatives lead by women's health nurses to build social capital and improve physical and mental health	Cross- sectional survey 2 time points (baseline and follow-up) Quantitative questionnaire	Increase in bridging SC. Decrease of negative attitudes towards neighbors	Improvement in women's perceptions of physical and mental health Fewer women reported that physical or mental health interfered with everyday activities. Decrease of negative attitudes towards neighbors

Heenan (2004)	N= 16	Cross-sectoral partnership between neighbourhood and statutory health services to provide health education and promotion	Case study In-depth qualitative interviews	Lack of mutual respect (between voluntary workers and senior management)	Volunteers experienced 'burn-outs' after 6 months of involvement. Increased levels of confidence and self-belief for volunteers.
Rios, Olmedo & Fernandez (2007)	Not reported	A Community Participation Strategy (CPS) project to improve the population's wellbeing	Mixed method evaluation Qualitative evaluations (methodology not reported) Quantitative evaluation: Net aggregation method (methodology not reported)	Decrease in the gap between the health services and communities.	Increase in ante natal care, PAP screening and family planning methods provision. (health effects of this not measured) A "visible change" in knowledge, attitude and practice of couples negotiating for and exercising human/reproductive rights. Decrease in the gap between the health services and communities.
Swendeman, Basu, Das, Jana & Rotheram-Borus (2009)	N= 220	An intervention to prevent STD/ HIV in sex workers: "The empowerment approach"	Quasi-experimental intervention trial. Control group receiving standard HIV/STD care. Evaluations for all groups at a baseline and at 3 time points post-intervention. Quantitative questionnaire.	Provided a frame to motivate change Built social support among sex workers	Improved knowledge of STDs maintained STD/HIV risk perceptions. Improved cognitive, affective and behavioural skills in sexual and workplace negotiations Summary outcome scores (the sum of scores for factors that prevent HIV/ STD infection) indicated increased scores for intervention sex workers, and decreased scores for control sex workers.

Research Methodologies

Of the 7 evaluations, there are 2 case studies, 1 single time point evaluation, 1 iterative PAR evaluation, 1 cross sectional survey with two time points and 1 quasi-experimental intervention trial. One study (Rios et al., 2007) did not provide enough information to describe their methodology adequately. Qualitative methods were used in 5 of the 7 studies and quantitative methods in 4. Only one study used a control group to separate the effects of the directly health-related activities and the CM (or as they call it, 'empowerment') approaches. Sample sizes were generally small, the largest being the cross-sectional survey study, with an N value of 328, and none report effect sizes.

Intervention Effects

Intervention effects can be divided into effects on individuals and effects on the community. However, these categories are certainly not mutually exclusive, and most interventions produced effects on both levels. Individual effects are diverse and include changes to physical and mental health (Ashwell and Barclay, 2001; Griffiths et al., 2009 and Heenan, 2004) and to self-confidence (Campbell and Mzaidume, 2001; Heenan, 2004). At the group level, two studies report explicitly on SC (Griffiths et al., 2009; Campbell and Mzaidume, 2001). Rios et al, (2007) Heenan (2004) Ashwell and Barclay (2009) and Crabtree and Wong (2001) report effects on the dynamics between communities and health systems, whilst Swendeman et al. (2009) report on levels of social support between sex workers.

All report positive impacts on the participating communities but 2 studies also report negative impacts: Heenan (2004) and Campbell and Mzaidume (2001) both give accounts of how contextual factors undermined the intended results of the interventions. Heenan observed difficult power dynamics between the government figures and community members whilst Campbell and Mzaidume found existing social tensions were exacerbated by the intervention.

Of the positive impacts reported, only 2 (Ashwell and Barclay, 2009; Griffiths et al., 2009) report improved health outcomes, despite this being the ultimate goal of many of the interventions. These are based on observations or self-reported perceptions, rather than quantitative or objective measures. More commonly reported outcomes referred to improvements in healthy *behaviours* (Ashwell and Barclay, 2009; Crabtree et al., 2001; Rios et al., 2007 and Swendeman, et al., 2009) or *knowledge* about health and wellbeing (Ashwell and Barclay, 2009; Pence, 1991; Rios et al., 2007 and Swendeman, et al., 2009). Reflections on *non-health related* outcomes include: improved confidence of participants (Campbell and Mzaidume, 2001; Heenan, 2004), a sense of community cohesion and shared objectives (Crabtree et al., 2001), improved bridging SC (Griffiths et al., 2009), and improvements in sex workers' skills in workplace negotiations, social support (Swendeman et al., 2009).

3.7 *Discussion*

Community Mobilization: What works, why and how?

There has been a call from both policy researchers (Rifkin, 2009) and the professionals involved in intervention programmes (Weine, 2011) for more investigation into "what works, why and how" in community participation approaches. As a whole, the literature presented in this review reflects the view that participatory approaches are strongly advocated as a means to improve wellbeing in a wide range of disadvantaged settings. It also indicates that there is a rich theoretical

background of literature that relates to community participation, social capital and the ways these could relate to health. However, these theories are rarely integrated into intervention designs in the field, and there is lack of evidence about exactly how CM operates within health interventions. It is clear that the effects of CM are multi layered and can be measured on both individual and group levels, but the majority of field research is not complex enough to capture this adequately.

There are several specific difficulties in using this body of literature to answer the question of what "works, why and how": Firstly, the low number of systematic evaluations of CM interventions make it difficult to come to reliable conclusions about what works and what doesn't work across contexts. Secondly, the concepts of wellbeing and pathways towards it are so varied, that there is no common indicator for effectiveness, and it is difficult to make comparisons across interventions. Finally, even when taken on a case-by case base, most of the empirical studies do not break down the effects of individual components of their interventions in their research designs, making it difficult to pinpoint *how* changes occurred. Mechanisms of change are speculated upon but rarely systematically investigated.

The authors of these evaluations propose several (collective) mechanisms for the way that CM affects wellbeing, which provide a useful starting point for future research:

- The building of bridging SC (Griffiths et al., 2009)
- Communities having a shared direction and objective (Crabtree and Wong, 2001)
- The creation of spaces for negotiation and argument (Campbell and Mzaidume, 2001)
- The creation of bridges between community members and public services. This could also be described as bridging Social Capital (Ashwell and Barclay, 2009; Rios et al., 2001)
- The legitimization and recognition of community activities in a wider social context (Crabtree and Wong, 2001; Swendeman et al., 2009)
- Mutual respect between powerful figures and non-powerful community members (Heenan, 2004)

All of the above are encompassed in the concept of Empowerment; a common theme that ran throughout the literature.

Implications of literature review findings for RMM. Understanding RMM as a multi-level intervention

The authors in this body of literature emphasise a range of different societal levels that different aspects of CM interventions to work on. These validate the organization of the RMM structure into Village, District and Provincial levels:

Village level:

In RMM, this is where the community network is established and community-lead interventions take place. In the literature, relevant activities such as Peer Education (Campbell and Mzaidume, 2001) and Participatory Action Research (Crabtree and Wong, 2001) are described. Through these types of activities, C**apacity building** and **community ownership** aspects of CM are addressed. In terms of Social Capital theory, it is where **Cognitive SC** and **Bonding SC** are built**.**

District level:

In RMM, the district level network ensures that community networks are represented amongst professionals and district authorities. In the interventions described in the literature, this includes

collaborations with local (health) services to improve access to care and functional systems of referral (Griffiths et al, 2009; Heenan, 2004). This creates **functional community systems** and has the potential to build **Structural SC** and **Bridging SC.**

Provincial level:
In RMM, this is concerned with the role of powerful structures such as governmental bodies. This is also described in the literature; namely by building advocacy and lobbying for a supportive political context (Campbell and Cornish, 2010). This creates the **wider social and political conditions** for RMM and builds **Structural SC.**

Strengths and limitations of Social Capital theories; Individual and collective outcomes
Only one intervention study evaluates the Social Capital generated by CM activities (Griffiths et al., 2009), despite this theory featuring heavily in the overall body of literature. This reflects the fact that that the theory (as it is understood) is difficult to operationalize in the context of complex interventions like RMM. This is at least true of Putnam's formulation of Social Capital- which the majority of empirical studies refer to. Because this formulation depends on identifying particular structures of social 'glue' (bonding, bridging etc.), there is less room to observe what community groups create from their own activities and processes. In this way, the less pre-defined perspective of Bourdieu may be a stronger framework for RMM. This approach focuses on the intermediate outcomes within groups that enable them to create new resources and achieve goals. The lack of pre-defined assumptions in this theory means we use RMM approaches to identify specific goals and outcomes such as participatory mapping, and activities that encourage financial and social solidarity.

A key finding of this review was that CM approaches are almost always a part of a broader and complex intervention, which promotes elements of individual health as well as collective action. Similarly, the RMM process can be understood as a complex intervention that works towards individual and collective outcomes, through different channels (i.e. different activities within the RMM process):

Individual Outcomes	**Channels**
- Self efficacy/ agency ←	Capacity building, health education
- Physical health ←	Functional referral systems to health facilities
- Mental health ←	Psychoeducation, community counselling

Collective Outcomes	**Channels**
- Collective efficacy ←	Sociotherapy, leadership training, action planning
- Functional community systems ←	Creation/ renewal of community networks
- Social connectedness ←	Ongoing community mapping exercises, network membership

Lessons learnt in the literature

Studies that reported in-depth, qualitative evaluation of interventions provided useful insights into the challenges and dangers of CM approaches in the field. Although contexts vary hugely across these examples, authors were able to reflect on the overarching reasons behind challenges and failures and this is a useful resource for other implementers such as ourselves.

- Campbell and Mzaidume (2001): Strictly hierarchical social systems and dominant figures can create impossible conditions for new community groups to function.
  In RMM, it will be essential to identify these social dynamics at the very beginning of the process through extensive context analysis and throughout the ongoing mapping exercises. As these dynamics have been shown to be extremely resistant to change, community mobilizers will need to ensure that they do not dominate/ paralyze the community networks.

- Heenan (2004): Too much pressure on community members to create change, without the necessary power or ownership of activities creates a dynamic of mutual disrespect between the community and authorities.
  The creation of district-level networks aims to involve professionals in sectors such as the health, judiciary and education systems. Village network members must also be represented in these networks, to ensure that they have a platform to raise issues at a higher level and their activities in more powerful social structures.

- Tribe (2004): The harnessing of local skills and resources is essential for the long-term functioning and sustainability of programmes
  Although RMM projects are generally longer term than the empowerment programmes reported by Tribe (2004), it is still necessary to mobilize existing resources. Community-based health-care such as traditional healers and midwives should be involved in designing and implementing interventions.

- Griffiths et al. (2007); Chau-kiu Cheung and Wing-chung Ho (2012): Building SC is a bidirectional process- it is not possible for individuals without the physical or material capacity to participate.
  *In the contexts in which RMM operates, this is a serious issue; public health is generally very low and time, money and resources are scarce. This means that the **content** of interventions is extremely important. Capacity building must focus on the basic aspects of health such as nutrition, hygiene and disease prevention as well as more socially oriented activities.*

- Griffiths et al. (2007); Heenan (2004): The simple provision of a resource or intervention cannot alone improve health outcomes.
  This is why RMM takes building social networks and strengthening social structures to be the core means to build Social Capital. It is less focused on providing resources and more focused on "building the ability of persons and families to command resources" (Bourdieu, 1979)

3.8 *Conclusions*

Despite the huge variety in interventions and concepts of wellbeing in this body of literature, there are clearly strong links and common themes, both between studies and with the RMM model that has been developed by the co-founders of C4C. It is important to ensure that these themes (such as social capital, participation and empowerment) do not exist simply as rhetoric in community development and health promotion (Evans et al., 2010; White and Petit, 2004), and that their complexity is fully recognized and explored in the development and evaluation of CM approaches. The literature in this review reflects the findings of Hawe and Shiell (2000) that the literature on Social Capital and health remains incomplete, but it does indicate that it is an active field of research, which is generating new ideas about the relationship between social processes and wellbeing.

The research conducted into CM interventions report on both individual and group level processes, which in turn, have various effects on the wellbeing of both individuals and communities. It must be remembered, however, that this is a pattern that has been observed in this small body of literature and is not a feature of health and mental health intervention research in general. Despite the shift towards community-based health work, there is a lack of rigorous research into the design, evaluation and reporting of interventions in group settings; with a tendency to assume that theories of individual change are generalizable to groups. Predictably, this is particularly pronounced in disadvantaged settings, where resources and capacity for this type of complex research is scarce. The reports and evaluations of CM captured in this review therefore represent an important but thin evidence base for community interventions. Incorporating theories and concepts of group processes into the development and evaluation of complex interventions will lay the foundation for building more complete, informed models of community mobilization.

4. Key Theories

Social capital was a key theory that was captured in the systematic review of evidence for community mobilization approaches. There are, however, 3 other landmark theories that have influenced the development of RMM from its inception. All 4 theories are fundamental to understanding the underlying ideas and principles behind RMM, and are briefly summarized below:

Social Capital
(Putnam, 1993; 1995, Bourdieu, 1979; 1980)

Social Capital has been linked to health and wellbeing in numerous ways (Hawe and Shiell, 2000) and has recently been linked to post disaster mental health (Wind & Komproe, 2012). As shown by the literature review, the most common formulation of Social Capital comes from Putnam. This is at least partly due to the fact that this theory is easily operationalized in sociological research: the concepts of Bridging and Bonding SC can be measured with specific indicators (e.g. through the number of civic associations people belong to or the degree to which people respond positively to a "community trust" item in a survey) and the direct association between Social Capital with public health or other public goods can then be tested.

However, the weak evidence base found in the literature for Social Capital as a direct means to improve health and wellbeing suggests that Putnam's formulation may not be the best model for RMM to adopt. As can be seen in our model of RMM (outlined in the following section), the means of creating social cohesion are *not* dependent on external resources and the outcomes are *not* predefined. This is because this model is far closer to the formulation of Bourdieu, who does not suggest a direct link between resources and specific outcomes. Instead, this approach focuses on the effect that Social Capital has on groups, which enables them to create their own beneficial outcomes from the resources available to them. The Bourdieu model of Social Capital-- which may be less easily-defined-- is nevertheless a better formulation for the RMM model in that it does not depend on predefined resources and structures to create a functional society.

A more in-depth presentation of Social Capital in relation to community mobilization and health can be found on the literature review in this guide (chapter 3)

Ecological Systems Model
(Bronfenbrenner, 1979)
Many of the activities and approaches within RMM require implementers to view communities through the lens of Bronfenbrenner's Ecological Systems Model. This model originated in child development theory and shows how every 'level' of a social system influences and interacts with an individual as it grows up in the world. These levels range from those closest to the individual (micro) to much wider social and political systems (macro). These levels can be used to describe and explain how different influences affect the wellbeing of a community. For example, wartime healthcare trends can have an influence on a micro level (whether a rural household can access care), a meso level (whether any well-trained health staff exist) and a macro level (The percentage of GDP that is allocated to healthcare after funding cuts). Crucially, these levels interact with one another; meaning that these large-scale economics not only affect individuals and families, but are shaped by public health and the functioning of individuals.

Conservation of Resource Theory
(Hobfoll, 1991)
This theory explains individual stress in relation to environmental demands. It posits that the promotion of wellbeing depends on the availability and successful management of valued resources. These resources can be material (such as medicine or books) or more abstract (self-esteem or community efficacy) and can operate internally or in the external environment. Without them, people become vulnerable to psychological and physical disorder and debilitated functioning. Hobfoll also draws on the ecological approach to emphasize the power of environmental obstacles; interventions must *"target resources and be intensive enough to change the ecology in which resources operate."* (Hobfoll, 1991)

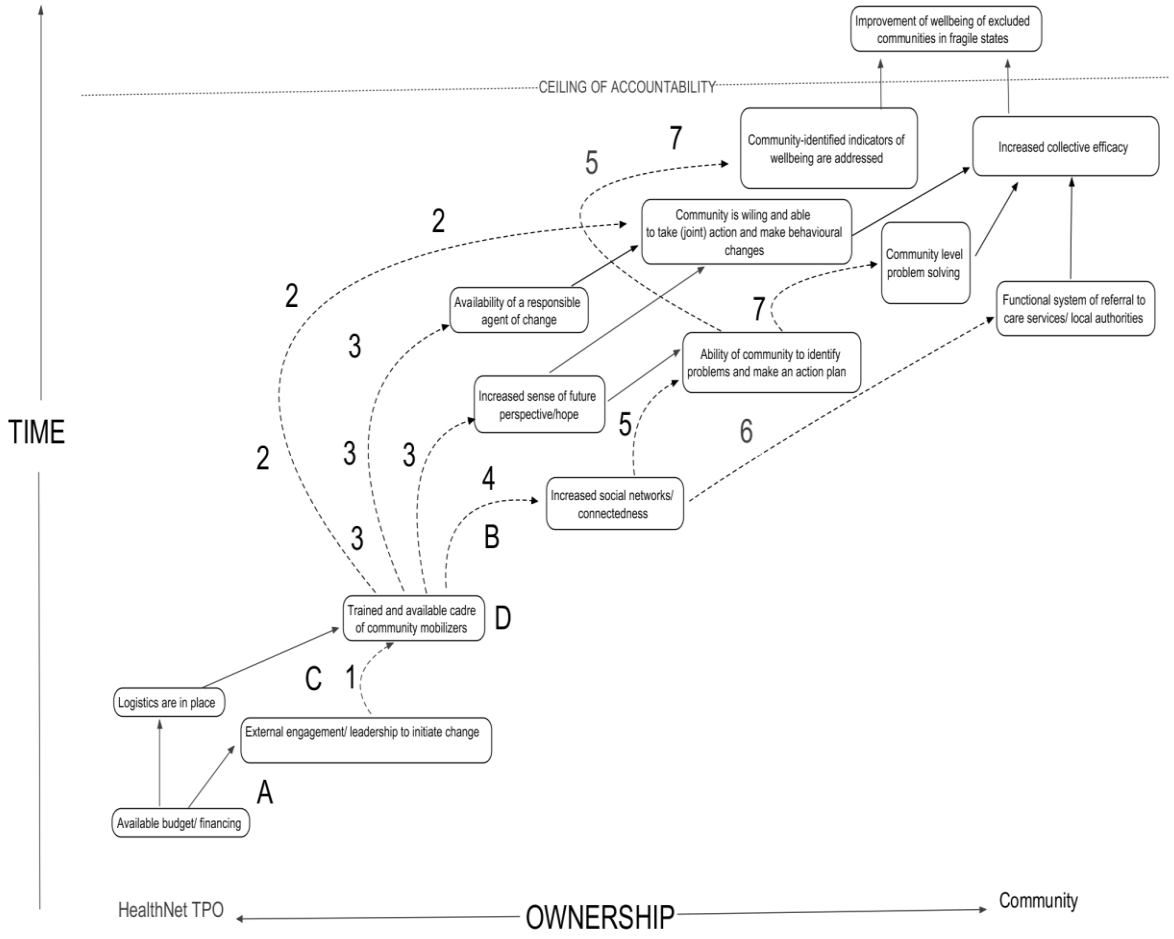
Collective Efficacy
(Bandura, 1998)
The psychological construct of Collective Efficacy in health promotion (Bandura, 1998) and disaster response (Benight, Swift, Sanger, Smith, & Zeppelin, 1999) is an extension of *Self*-Efficacy; the belief that your actions will lead to positive outcomes. Collective efficacy is therefore the sense that the group you belong to is capable of successful collective action, such as community public health promotion. This relates to conservation of resources because it can be seen as both a means for a group to manage resources and a resource in itself that makes actors in group work successfully together. It also of course depends on having the actual skills and competence to make this possible and reinforce the belief.

5. Conceptual model

5.1 *A Theory of Change map of the RMM process*

This section will present a conceptual model of the RMM process. The model should not be seen as a step-by-step guide to implementation (see the RMM Protocol for more practical implementation advice;) but rather an overview of the "building blocks" of the RMM process. This process can be represented with a Theory of Change map. Creating a Theory of Change is an outcomes-based method for designing complex interventions or pathways to social change[11]. It results in a visual map, which sets out a series of conditions or intermediate steps that need to occur to bring about a long-term goal. It also specifies how these intermediate steps are linked and what action needs to be taken to progress from one to the other. These activities (interventions required to connect one precondition to the next) and assumptions (characteristics of the project context or necessary conditions for the interventions) are listed and marked on the visual map in the form of numbers and letters. The result is a model that sets out a realistic pathway to change.

[11] DfID review of ToC use within international development, Vogel, 2012: http://r4d.dfid.gov.uk/pdf/outputs/mis_spc/DFID_ToC_Review_VogelV7.pdf)



Assumptions

A. There is a situation of relative security, no ongoing violence.
B. Years of war and violence has affected the social fabric in the community
C. Previous work has resulted in an in-depth understanding of socio-cultural context and knowledge of local needs and perspectives (context analyses)
D. Minimal (financial, human) resources are available in the community

Activities

1. Training is provided for mobilizers
2. Education/ capacity building for community members
3. Running Mapping exercises
4. Creating networks at muiltiple levels (village, district, provincial)
5. Running ToC workshops (CMs)
6. Coordinating intersectoral collaboration
7. Facilitating action plan using community identified interventions

Nb The activies on the figure mark the FIRST TIME that activities should be carried out- this is a minimum and they can be returned to and reinforced throughout the process

Figure 3: The RMM model as a Theory of Change

The model works along two dimensions: time and ownership, meaning that as well as working 'upwards' through time, these building blocks move horizontally along the scale from NGO to community ownership. By the final stages of the RMM process, conditions such as "increased collective efficacy" are entirely independent of the implementers of the project. The intermediate conditions are focused on preparing the community for autonomous action.

The "ceiling of accountability" refers to the limit of the NGO's direct effect on the community. For example, RMM creates the *preconditions* for improving individual health and wellbeing, but does not directly work on this level. RMM therefore aims to build the resilience and social functioning of a community at large; individual health outcomes will depend on *subsequent* interventions and more specialized services.

5.2 *Assumptions*

Assumptions A, B, and D- described in figure 3- pertain to the existing conditions of the community. Whilst it is problematic to attempt to provide a comprehensive description of "fragile states" (given the vast differences between the different contexts RMM is applied to) there are nevertheless some common characteristics that should be recognized in post conflict or disaster zones. For example, the almost inevitable lack of wealth and resources; and the breakdown of trust and cohesion between certain social, cultural or political groups.

Assumption C refers to the existing attitudes and understanding of project developers, with regard to the context that RMM is being applied to. A good understanding requires close, dynamic assessment of the community and a consideration of its history as well as its present state. This is described as 'context analysis,' and underpins the principle of working with existing structures and practices in a community.

5.3 *Activities*

The key activities are represented by numbers 1 to 7 and are attached to the dotted lines connecting each condition. These activities involve input from the organisation, institution or persons implementing the programme, particularly in the initial stages. However, these interventions aim to build the capacity of community networks, so they can eventually organize interventions independently. Therefore, they begin being based around specific protocols such as *activity 1: "Training Community mobilizers" and* result in community-driven interventions in activity 7. The solid lines represent transitions that occur *without* the need for an intervention activity.

Education/ Capacity building (activity 2) is represented by an arrow that spans over several stages. This is because the timing and modality of this depends entirely on the community in question. In some contexts (such as Burundi, where community mapping is considered an important first step), this training would come *after* mapping exercises (activity 3). However, in another context (like South Sudan), communities might report that people are not motivated to take part in mapping exercises without receiving some training first. As such, this intervention must be flexible in its application.

Mapping (activity 3) is an important stage in the model, because of the joint involvement of implementers and community members. As well as identifying the mechanisms that could help or hinder development of services, mapping brings people together in a constructive space, which in

turn results in: insights into "entry points" of the community, detection of power imbalances or harmful practices and enhanced use of existing resources.

Creating Networks (activity 4) is where new social structures are established. It is important to create networks on the village, district and provincial levels, so that grass-roots activity can be communicated to other networks and supported by professionals/ authorities.

The Theory of Change workshops (activity 5) are aimed at Community Mobilizers, to familiarize them with the Theory of Change model and the outcomes-based approach to creating change. See annex 2 for a tool that is currently used the Theory of Change workshops for community mobilizers.

Inter-sectoral Collaboration (Activity 6) refers to the involvement of existing formal organisations, such as health services, schools and local authorities. This is an essential way to get the input of professionals and experts for more specialized interventions, and to ensure that people with severe or complex problems can be referred to the right service or support. See component 5of the RMM protocol: "From RMM to specific service delivery" for an illustration of how this works in practice.

Activity 7, 'implementing a Plan of action using Community Identified Interventions' is also part of this component in the protocol (component 5). However, not all these activities require professionals or links to public services. Some interventions are anchored firmly within the community groups themselves and are focused on social/ emotional support or financial solidarity schemes. See page 42 of the protocol for examples of community-based intervention activities.

5.4 *Application of the model*

By breaking down the process into building blocks and pathways to change, we were able to gather data about each stage of the process. This is useful for both the development of the approach (problem identification, fine-tuning etc.) and is also the first step towards an *overall* evaluation of the approach. See section 7 of this guide for a tool for carrying out this type of research, known as a Process Evaluation.

6. The Protocol in practice

Photo 2: From planning to action; Gitega Province Burundi

6.1 *How to use this protocol*

These guidelines have been written for all implementers of RMM related initiatives who are involved in the design and implementation of activities and those who are involved in community-based psychosocial work. The aim is to discuss how to bring the RMM concept into practice in the different contexts, rural and urban, where community-based activities are implemented and to reach a common understanding of opportunities and challenges in adopting the RMM approach as developed by the co-founders of C4C and while designing and implementing different programmes.

The point of departure has been the RMM Framework as defined by the Global Fund[12]. This framework has been adapted by the cofounders of C4C and can be summarized into the following components:

1. **Conducting community mapping exercises** to identify, describe and analyse the individual and collective mechanisms that help or hinder the health and well-being of the local population
2. **Establishing networks** at different levels of society to build social cohesion and the potential for collective action.
3. **Developing concrete action plans** for long and short-term goals, in strategic workshops lead by community mobilizers.
4. **Capacity building** in a process of direct empowerment through education and participation.
5. **Community activities/ interventions** implemented by empowered key figures and/or referral towards a more specific service delivery.
6. **Monitoring & Evaluation (M&E)** of each stage of the process.

[12] The Global Fund (2010). *Community Systems Strengthening Framework.* http://www.theglobalfund.org/documents/civilsociety/RMM_Framework.pdf

These components will make up the structure of the following protocol and summarize the key steps of the RMM process. However, before describing them in full detail, it is important to note that they should not be seen as an entirely predetermined sequence. Conducting an overall context analysis to start with is a precondition but the specific components of the framework can take place in an adapted sequence, sometimes simultaneously and sometimes some previous steps will have to be repeated to fine tune plans and actions. The way in which the RMM approach is implemented is and should be a flexible and creative process; all will depend of perceived needs, human and material resources, geographical and cultural context and type of required action (emergency versus rehabilitation). The following examples illustrate this and give an insight into the variety of field contexts that RMM has already been implemented in:

- In a country like Afghanistan, where the approach has been used to implement a project where the target group and outcome were determined beforehand (empowerment of a specific number of women and combating domestic violence and other harmful practices) but where the target area was relatively unknown,, community mapping exercises (component 1) were essential first steps in order to find out at what level platforms and networks could and should be established and who should be the participants that would be able to undertake action as a next step.
- In Burundi reinforcing existing networks and setting up networks at different levels of society (component 2) appeared to be a relatively simple exercise. In Burundi many networks were already in place (clubs, associations, CBOs, faith-based organizations, elderly etc.), many young (well educated) people feel the urge and are ready to undertake collective action and the small size of the country and relatively good infrastructure, makes it easy to travel and exchange. Here the networks were reinforced and established before completing mapping exercises. Essential information was even obtained as a result of the establishment of these networks.
- In South Sudan, conducting mapping exercises as a first step had a contrary effect: here, most villages had become so dependent of external help that obtaining information from villagers without providing them with 'something' in return resulted in feelings of frustration and boredom. Within this context, some initial general broad-based sessions or campaigns to raise the awareness about urgent problems (the relation between alcohol abuse and rape, high prevalence of malaria, HIV/AIDS etc.) might have generated feelings social cohesion that may have elicited valuable insights about (health) believes or underlying (social) dynamics later on.
- Finally, in an emergency context such as the protracted conflict in Syria, huge numbers of people are forced to seek refuge in neighbouring countries. Here, providing psychosocial 'first aid' and assistance to the people in need should be a very first step, which can be followed up by the establishment of networks in a later stage.

6.2 *Initial considerations*

Before implementing RMM in any context, it is important to establish that- in practice- community mobilization is a complex and challenging process, which can rarely be applied in a predefined or straightforward format. Our experience highlights the need for careful consideration of what participation can realistically hope to achieve in severely constrained

settings. An understanding of the following obstacles and limitations of RMM is a vital precondition for exploring the intended goals in the remainder of this guide.

6.3 *Local Instability*

Certain risks are inherent in using the RMM approach in fragile, war-torn or post-disaster environments. Local instability and powerlessness can seriously challenge commitments to the principles of participation, and the introduction of resources into resource-scarce, violence-ridden settings may disrupt delicate community cohesion. Individuals with agendas within exiting conflicts may take advantage of the collective process to bias, intimidate, or highjack community intentions. Further, the most appropriate timing during the conflict or post-disaster recovery process for launching a RMM approach is much debated. The risk of premature engagement is that communities are simply not in a position to put energy and trust into such an initiative.

6.4 *"Anti-Social Capital"*

The complex social dynamics involved in participatory approaches in general have also been recognised in the literature on Social Capital (see section 3; the Literature Review), as different models of community participation can lead to both positive *and negative* aspects of social capital. Community dynamics, particularly in marginalized, disaster-affected settings can result in what has been termed "anti-social capital" (Wakefield and Poland, 2005). Increased social bonds and trust do not necessarily imply increased equity and may instead lead to increased social control both within and between groups. Thus, the ''dark side of social capital'' can exclude those who are unable or unwilling to conform.

There is also a danger that policies will focus on the cohesion between members of different groups without addressing fundamental inequalities in their access to resources. This may in fact exacerbate rather than solve existing problems. Sensitivity to the way individuals are embedded in social structures is needed to ensure that attempts to build social capital do not compromise equity and social justice.

6.5 *Creating change vs. working with existing structures and values*

Tensions can arise when a project aims to make major changes in a community whilst also trying to work *with* existing structures and values. Clearly, these two principles are not always compatible, and this presents an ethical issue that must be carefully managed. Working with social norms and hierarchies where they work well is a key strategy used to encourage participation in RMM. But where they don't work well, it can do more harm than good. An example of this tension arises when faced with the fundamental Islamic values of gender relations between men and women in the context of a RMM programme for women in Afghanistan. Unlike other values (such as strong family values and community bonds) gender discrimination stands opposed to the principles and goals of the RMM programme. In terms of community structures, the problem may arise when a religious institution such as the Church is opposed to progressive initiatives such as family planning services. To manage this, community actors must highlight and critically reflect on existing structures and values, and how they impact on the wellbeing of their community. Whether they are maintained and incorporated in activities, or challenged, must be considered on

a case-by-case basis. More importantly, changes must be led by the community and not by an external agency (i.e. the NGO facilitating the programme).

The following minimum conditions are practical strategies to help maximize the potential effectiveness of a RMM approach in a (post) conflict and/or disaster context:

- *Basic security.* Community members should feel free from physical threat and should be able to move about within their environment without fear.
- *Information on social dynamics.* Introducing RMM into the delicate operational conditions of a conflict-ridden environment requires a good understanding of the local context. This includes its history, conflicts (community, regional, and nation-wide), the economy, and socio-political structures.
- *Sufficient community capacity*. The community should possess sufficient membership, time, ability, and authority for genuine participation in planning and implementation. Communities emerging from conflict or disaster tend to be especially under-resourced, under-educated, and under-skilled; capacity building becomes a particularly prominent component of the RMM approach in war-affected communities.
- *Financial distribution mechanism*. A RMM project requires a system through which to distribute funds. This could be as basic as community-based safety boxes or a pass-through arrangement with an international organization or more sophisticated as a banking structure. The safety and accountability of the mechanism, however, is critical.
- *Qualified facilitators*. The RMM operational structure relies on literate facilitators with local language skills and a keen understanding of local political, social, and conflict-related dynamics. Their image should be one of impartiality to the conflict. These facilitators are a central element to the success of using a RMM approach in conflict-affected environments.
- *[Ideally] Government legitimacy and capacity.* Optimally, government structures should have adequate legitimacy, human and material resources, and administrative capacity to interact with communities. In conflict environments, however, governments may be non-existent, illicit, weak, or overwhelmed and this may not be realistic. Nevertheless, linking a demand-driven approach to the development of government structures is a critical element to sustainability.

The way in which the RMM approach is implemented, therefore, can be highly supportive of building cohesive communities, or it can be equally destructive. The process becomes magnified when social relationships have been rubbed raw by violence. Particular care and attention to developing trust, inclusion, and accountability through the various stages of the process (while planning, mobilizing, implementing, and evaluating activities) is essential. This puts substantial weight on the content and quality of the facilitation and highlights the need for continual monitoring of power relationships, elite capture, participation, and leadership roles. Equally critical is a clear understanding of the community history and social dynamics and the constant reviewing of the impact of interventions on the local context.

6.6 *Preconditions for using the approach*

Available and well allocated budget

RMM focuses on enhancing voluntary community engagement in all aspects from planning to on-the-ground action. Although the RMM approach is not costly in itself, experience learned that an underestimation of necessary costs of implementing and organizing activities can have serious consequences. Activities aimed at mobilizing people create expectations among participants; limiting the number of activities, changing strategies or ending activities without ensuring a follow-up as a result of this underestimation of the real costs not only means a waste of human resources and services put in place but also can cause (or add to the existing) mistrust among the participants. This can in turn, become a disincentive to future participation in other programs. It is vital to have a budget that takes into account the cost of practical elements of implementation (transportation, administration, etc.)

External engagement to initiate change

Although the aim of RMM is to reinforce local ownership, in many cases, an initial push from outside is necessary to set a possible chain of changes in motion. This initial push is not a predesigned or imposed intervention strategy but consists mainly of putting the other necessary preconditions in place. This includes the establishment of a team of staff members with relevant and appropriate knowledge (see below for necessary attributes of community mobilizers). The external engagement is in most cases an organizational initiative with the financial backing of a donor. Once this initial push has been given, the major objective is to reinforce local ownership while making efforts sustainable. Succeeding in this will ensure the actions, activities and interventions can continue after funding from external donors is withdrawn.

Reinforcing local ownership asks for a flexible organogram (organisational structure) where local initiatives are encouraged and where external actors make space for local initiatives as soon and as early as possible

Available cadre of community mobilizers

Community Mobilizers (CMs) play a key role within the RMM approach. Besides knowledge about community mobilization techniques (group mediation and basic knowledge about psychosocial issues) they need to have specific skills in order to negotiate with stakeholders at different levels and within different contexts. They also have to be able to deal with conflict-affected people and recognise power relations. There is no exact profile of a community mobilizer; all will depend on the context in which he/she intends to work. In general, a community mobilizer should:

- Come from the target province/district where she/he will be active, speak the local language(s) and be familiar with the local customs.
- Have enough authority to take the lead and initiative to instigate change
- Have knowledge of primary psychosocial and health related issues such as: gender-based violence, child rearing, alcohol abuse, human rights, and life skills.
- Have skills in health education (FP, HIV/AIDS, STD, hygiene, diarrhoea), basic mental health care, supportive counselling and running support/self-help groups,
- Have skills in interviewing, facilitation, social mediation and negotiating.

- Have (basic) report writing and monitoring abilities

As community mobilizers play such an essential role, it is important to make optimal use of their capacity, experiences and skills. Most organizations have a hierarchical organogram in place in which field workers such as community mobilizers would figure at the bottom. However, within the context of RMM, community mobilizers are the main implementers and often the only ones that have an in-depth understanding of activities, local context and available resources. Community mobilizers should be valued (and paid) according to what they deliver, to their skills and seniority. Because they come from the target area where activities are implemented and- in most cases- will continue to be key players in similar activities once projects have come to an end, their active involvement, enthusiasm and willingness to initiate change are crucial. Sufficient time will have to be allocated to the capacity building of these key stakeholders and organizing moments where community mobilizers can interact, exchange, learn from other's experiences. From the beginning, community mobilizers must be involved in all aspects of the project, from planning to on-the-ground actions, while being encouraged to undertake new initiatives and expand/build upon their actions as the programme progresses.

Logistics in place

RMM related activities are highly dependent on functional logistics. Community mobilizers spend most of their time with the local population, which means they are travelling on a daily place to different and sometimes very remote areas. Besides the availability of sufficient cars/drivers and where possible motorbikes, the planning of activities in itself also deserves due attention and is more than the development of weekly or monthly plans about what activity will take place where. Necessary protocols (e.g. security measures) and means (e.g. computers) must be available and basic materials have to be developed (IEC materials). Enough time should be allocated from the very start of a program to put a comprehensive and reliable logistic system in place

Context analysis

An in-depth, participatory context analysis is essential in the establishment of a RMM programme. Before making inventories of a specific 'community', an overall contextual analysis of the country is necessary, which has to then be made specific to the province(s) where activities will be implemented. This analysis will provide general information about the country and specific information about the right entry points per province; organisations, agents, groups, and key persons that are relevant to perform a more specific needs, capacity and strength assessment. Such context analysis should include information about specific areas; the characteristics of an area (tribes, customs, environmental issues, histories of/ current conflict etc.).

Relevant data to be collected;

General demographic and contextual information (that affect health and psychosocial well-being) at *country and provincial level:*

- Population size of the target area, composition of ethnic groups and estimated number of vulnerable people (displaced, children, refugees, etc.)
- Political trends and governance of municipalities

- Prevalence of Sexual and Gender Based Violence (SGBV) and the state of impunity of perpetrators of such practices
- Economic trends, livelihoods & food security; the prospect of increased economics (for young people) in the private sector
- Social trends and the level of damage to the social fabric of the community
- Thematic trends: (Health, Education, Water and Sanitation)
- Traditional local figures (leaders, elders, traditional healers etc.) and role of religious leaders
- Relevant target groups to work with and entry points into these groups
- Other characteristic and relevant information (ethnic conflicts, natural disasters etc.)

6.7 *Component 1*

Community needs, capacity and strength assessment/mapping

The aim of the Community Mapping exercises is to identify, describe and analyse the individual and collective mechanisms (which can differ from community to community) that exist in a community. It highlights mechanisms that may help or hinder the development of functional systems of care in future stages of the RMM process. It highlights the social determinants of health; including food security and livelihoods, education, income, local institutes, and strong and weak aspects of governance, gender inequality, discrimination, power dynamics, security, social justice, shelter, peace. By identifying, describing and analysing the existing structures and social systems within a community, eventual negative consequences of systems (inequality, power imbalances, and (traditional) harmful practices) can be detected and addressed. This is an essential precondition for the development of sustainable and accessible services. It can also enhance the utilization of existing resources and healing practices within the communities.

The mapping exercises are a basic intervention in itself. *Firstly,* discovering and prioritising, *together* with the population in fragile and conflict-affected states has the potential to revitalise the interpersonal connectedness that has been affected by war or disaster. The line of approach focuses not only on problems and problem solving but on resilience, empowerment and accountability. And *secondly t*hese exercises permit to identify the key figures within each community (members of the so called "comités colliniares") who will be able to take the lead and who can and will be helpful in a next stage (see component 2).

Mapping in practice

Most people are not used to working or providing information without getting something in return. Mapping exercises should therefore be combined with awareness-raising about the purpose of RMM, (the causes and consequences of) major problems and some psychoeducation from the very start. Obtaining and providing information can be easily combined in such meetings, in order to create a shared understanding amongst participants.

At this stage, it is also important to combine theory and practice in order to make obtained knowledge and information 'visible and tangible'. Making drawings of each community during the collection of information can be a collective exercise and is an excellent way to demonstrate how problems and resources are interrelated. Moreover, working on this as a group can have a healing

or therapeutic effect in itself. The drawing exercises should result in a visible situation analysis of each community; it should give a clear picture of problems, resources and the connections between them (as a sort of baseline). Colours, symbols and pictures should be explained in a legend. These drawings can also be used during awareness raising sessions with key persons in the different communities in which RMM activities are planned.

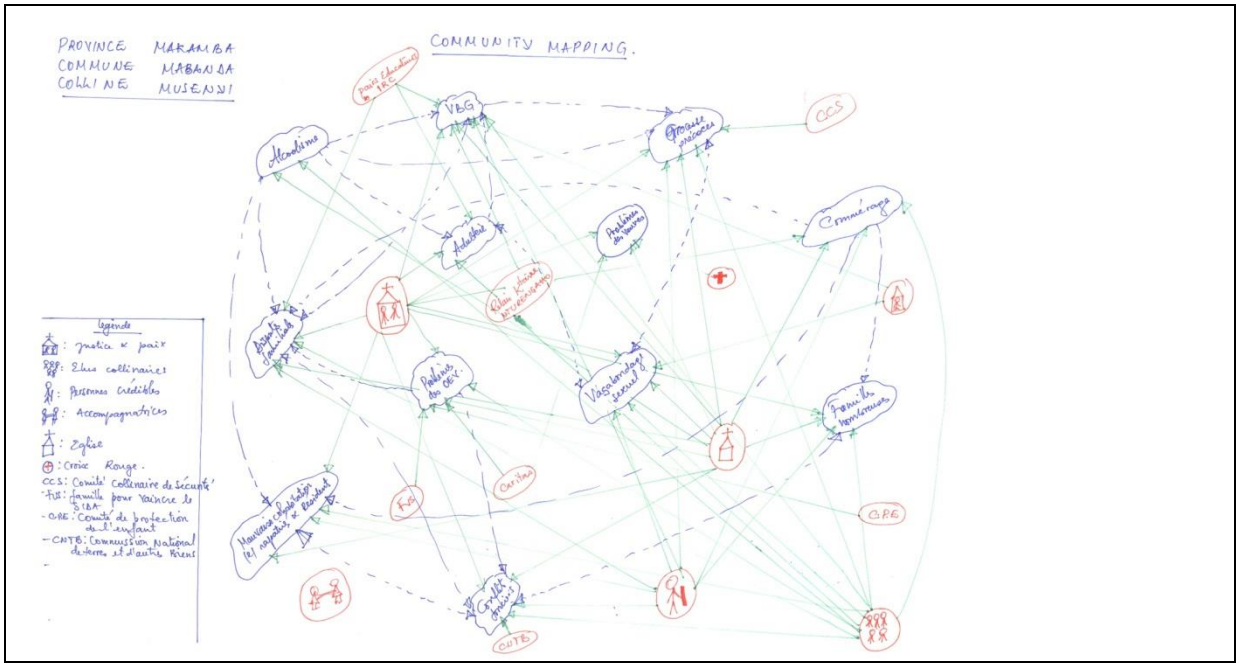


Figure 4: Example of a community mapping drawing (Burundi)

The collection of relevant information is not the same as undertaking semi-structured interviews but is an on-going process. All people living in a community can provide valuable information at any moment. A lot of information will be obtained simply making this kind of contact. The best way to record information is to use a checklist, which can be constantly added to.

Lessons learned

Experience taught us that 'mapping communities' takes quite some time. At the start of the SRHR program In Burundi, it took some 4 months to gather basic information in some 100 communities. The 'mapping exercises' were also used to build personal relationships with key figures at the different levels and to conduct awareness raising sessions about identified problems. RMM staff members indicated that they needed this time to gain trust and to discover underlying patterns of problematic behaviour. For example, when asking about major problems, all kind of issues came up except the fact of having large families. After several discussions, RMM staff and community members discovered that having large families appeared to be a major, although silent concern, with all kinds of direct and indirect consequences (poverty, land disputes, alcohol and (domestic) violence to cope with daily stress etc.). It also became clear that irresponsible behavioural patterns are mainly the result of a lack of knowledge and that widespread rumours about the side effects of Modern Contraceptives withhold people from using these family planning methods.

6.8 *Component 2*

Building community networks, linkages, partnerships and coordination

On the basis of information gathered in the mapping exercises, context specific changes can be made, which enable community actors to form new networks and linkages. The aim is to create a structure where key-figures, (local) organisations and governmental institutions can work together and take on responsibilities. Effective implementation of programmes requires inter-sectoral coordination and agreement among diverse stakeholders on different levels. As the implementation of community-based interventions may include a broad range of activities, many stakeholders can play an important role here. Possible stakeholders are government ministries (mainly Education, Health, Social Work), provincial and local authorities (Health, Women Affairs, Education, Religious Affairs, Justice, Social Affairs, and Rural Development), INGOs and NGOs, Community Based Organisations (CBOs), and relevant associations from the private sector.

Collaboration between different stakeholders is essential. Regular task force meetings, workshops and other collaboration efforts should ensure inter-sectoral coordination. Diverse actors should come to a negotiated agreement on an overall strategy and division of labour that supports affected communities [13] .

Establishing new networks at *different levels* of society is key within any given context, in order to ensure that the programme is embedded within the social structure. To become functional and powerful, community mobilization and participation must be supported by professional systems and political structures, as well being driven by grass-roots forces.

Building community networks at different levels: Networks on community level and identifying a key group of principal actors

The major objective here is for community members to interact, coordinate and offer their responses to the challenges existing in their communities. To achieve this goal, the network at the community level should preferably consist of a heterogeneous group of young and old, male and female key figures, representing different areas of life. Many questions arise when talking about community-based networks:

- Who should (or should not) participate?
- How many members should be part of this network to ensure the functionality?
- What are the local political, social, and conflict-related dynamics or gender imbalances?
- How to include marginalized groups?

The establishment of these networks will sometimes be easy and sometimes more difficult. In most cases an informative meeting with the community leader automatically leads to a first gathering with relevant people that are capable and in the right position to address needs at grassroots level. Besides the community leader, members of this network can be religious people,

[13] In this phase a negotiation process starts between identified stakeholders. The results from the mapping guide this negotiation process. Negotiation entails discussing which types of interventions might be appropriate for the problems identified, including local and foreign traditions (e.g. biomedical approaches, traditional medicine, etc.). The word 'negotiation' is used here to focus attention on the sometimes asymmetrical power relations that often exist between key stakeholders with different interests (e.g. church versus health staff)

elders, teachers, representatives of CBOs, Traditional Birth Attendants (TBAs) etc. In most cases, members of this network are people that are already consulted for being trustworthy, just, and having knowledge about the community. But many more people can adhere to this network, depending of needs, results achieved or unexpected challenges. The establishment of this network appears to be a relatively organic process, but on-going monitoring of activities should ensure that basic principles and agreements are followed-up upon.

Lesson learned

When the networks at community level in Burundi were established, large audiences (sometimes up to 200 villagers) indicated they wanted to become a member, even after explaining them that only some 20 members per community would benefit from capacity building workshops in a variety of issues (see component 4). They stressed the fact being an 'official member' was important for them. Later in the process, these broad-based networks didn't appear to be sustainable; being a member generated expectations that could not be fulfilled (material goods). The community mobilizers decided to return to the initial idea and limited these networks to some 20 to 25 members (comités collinaires), while applying selection criteria of being trustworthy, capable and in the right position to initiate change. Once this key group has been firmly established, the network gradually started to expand again but this time the adherence to the group appeared to be based on more realistic expectations

While considering the preferred heterogeneity of the group, it is important to note here that the establishment of networks is *not* about the inclusion of the poorest and/or more marginalized. Members of these networks will have to be selected for their potential capacity to initiate change and act as an example for other members of the community. It is their responsibility to ensure that the poorest and most marginalized benefit from the network's work to improve the overall wellbeing of the community.

The first activity to conduct with a community network is an open discussion about the major concerns and problems as determined during the mapping exercises. Problems arise when there is little trust between the local population and its leaders or among the leaders themselves. In this case some extra steps towards reinforced leadership and trust are needed before a network at community level can become functional.

In the case of controversial issues, like for example, the role of the Church when promoting modern contraceptives or family planning, meetings can be organized with a selected group of participants of the network and if needed, with other key persons (medical staff of the nearby health facility, religious people who practice a different religion, leaders or nearby villages etc.) in order to reach a consensus about how to proceed. Participants of the network generally indicate that as an 'organized' group of people they are confident about the role they can play in reducing problems that affect their community like over population, domestic violence, alcohol abuse, inter-relational conflicts and other problems as long as their capacities are reinforced.

Once the capacity of the members of the network is reinforced (see component 4), these same people will be responsible for conducting broad based (health) awareness or educational sessions for other community members (component 5). This is known as 'cascade learning' and ensures that skills and information reach the wider community.

Networks on District level

The importance of establishing a network at the district level is to involve local authorities and organizations, who can support the networks and community level and represent the community network at a higher level. In many cases, the establishment of a network at District level will pave the path to the establishment of networks at other levels. In the beginning of the SRHR project some 10-15 people were invited to become member of the networks at District level. As well as one or two representatives of each community, a network at district level should have representatives from professional and governmental bodies. In practice these groups did not function. Key people at District level are most people that have many other tasks and obligations. We decided to reduce this group to 6 or 7 persons[14]: During the first meetings, both short- and longer-term outcomes are discussed based on problems identified at the community level. The major aim of a network at District level is to ensure a proper coordination and follow-up of activities that take place at community level. The main activities at this level will consist of:

- (Bi-) monthly meetings to determine the actions needed to address problems raised by the community level representatives. Examples include mediation in case of land disputes, involving the police in case of rape, organization of campaigns to get the attention for major issues such as family planning.
- Division of tasks and responsibilities for identified actions
- Occasional training sessions by RMM staff members or other 'experts' (members of the network) based on perceived needs over time

Networks on Provincial level and National level: integrating the principles of the RMM approach in policies and strategies

The major objective of establishing a network at Provincial is to inform key stakeholders about the purpose of RMM related activities and to create a supportive, and active, platform for the activities that take place at District and community level. Establishing networks at this level is not an easy task. Most stakeholders have a busy time schedule; they have many other obligations and will not see the additional value to adhere to a new platform if they don´t see clear benefits. The first step here is to find out who the important key players are. Sometimes it will be more logical to participate in existing platforms; in other cases, regular meetings with individual stakeholders will yield some first results.

Lesson learned

One of the lessons here is that establishing a network at provincial level is only really effective when the coverage area of the RMM related activities is large enough (i.e. multiple districts in one project setting) and key people at provincial level feel that their involvement is worthwhile. Nevertheless, having regular meetings with those involved at provincial and-or national levels is highly recommended, even in earlier stages of a project, in preparation for more structural action later.

Establishing networks at Provincial level requires close collaboration with National level bodies. The Ministry of Health (MoH) might seem to be the most appropriate governmental stakeholder

[14] Titulaire de la promotion de la Santé, titulaire du Centre de Développement Familiale (CDF), l'Administrateur Communale, le Président du Tribunal de Résidence et Directeur Communal de l'Enseignement, Point focal de la Santé de la Reproduction

at this level, but other Ministries might play an important role depending of the context and purpose of the programs[15]. Within the context of the SRHR project, establishing a strong relationship with the Ministry of Education is important to integrate SRH related themes within the official school curricula. Ultimately, on-going lobbying and advocacy efforts should result in the establishment of linkages with national policy makers, e.g. on community health development, in order to ensure that all the activities fit into general national policies and strategies on community development.

The sustainability of networks

The sustainability of the networks at grassroots level should be somewhat ensured once the capacity of its members has been built. This finding is in line with experiences from Burundi, where the training of key figures in SRHR related issues reduced the reliance on staff of NGOs or local authorities. However, real sustainability of these networks and other community-based structures remains a huge challenge.

The concept of 'solidarity boxes' appeared to be very successful within many of the RMM project contexts. A group of community members make a commitment to regularly contribute to a money box and periodically decide on mutually beneficial ways to spend it. This system is no new phenomenon in most countries and can be relatively easily applied, provided certain criteria (division of responsibilities, a bottom-up approach, leaving initiatives and decisions to the participants) are clearly defined and respected.

As long as the principles of the RMM approach are not integrated in national policies and strategies, the sustainability of networks at district and provincial level will remain a complicated issue. Members often have real costs (transportation to the villages where they have volunteered to intervene, communication costs to coordinate action etc.) but obtaining money from an external source is rarely an option under limited project budgets. Providing performance-based incentives is an option but this might also generate negative motivations to adhere to a network or platform. One possibility is to create registered associations/community-based organisations (CBO), enabling community based structures to apply for national funds.

As the sustainability of action remains one of the most challenging issues, C4C is looking for more opportunities within the domain of financial inclusion through linking services and initiatives with Saving and Loan Systems, mobile phone banking services, Income Generating Activities etc.

Visibility

At this stage, the visibility of RMM within the Provinces, Districts and communities deserves due attention. Raising awareness about RMM activities can be done through a number of channels: the development of posters, flipcharts and leaflets; purchasing T-shirts for volunteers; developing audio visual materials that can be shown in schools, during events, on television etc. . All these activities help to keep RMM alive and recognised by the wider population.

[15] Appropriate stakeholders at this level vary by country; for example, in Burundi this appears to be the Director of Health Promotion and Hygiene (as part of the MoH)

6.9 *Component 3*

Development of an action plan and intervention continuum

Based on the identified and explored problems, needs and available resources (component 1) and the formation of a network of social agents (component 2) a plan of action needs to be drafted as to how a support mechanism will be established and put into practice. Only after analysis of the obtained data from mapping exercises, can specific interventions be designed with the stakeholders. Interventions are not pre-designed, but depend on existing human resources, available services, organisations and agencies (both public and private), contextual factors (demographics, infrastructure etc.,) and on the on the needs and (lacking) resources that have been identified during mapping. Here the focus is on both priority-setting and actions that will enable plans to be implemented meaningfully. This component of the framework may well have to be applied at multiple stages of the overall process.

The role of Community Mobilizers or local agents of change

The community mobilizers play an essential role in this phase of the process. When setting priorities and translating the results of the mapping exercises into concrete action, some objectivity is needed. It is unrealistic to expect a heterogeneous group of people to have the same short-term priorities. This conceptualization of overall goals is essential in bridging the gap between the various goals of the network members and the feasibility and appropriateness of the steps need to reach them. CMs should facilitate action planning workshops using an outcomes-focused approach.

Because a single intervention is unlikely to meet the identified needs of a whole community, multiple interventions will need to be amalgamated into a working *system* of support; i.e. an intervention continuum or set of packages, which address multiple needs. Such approach does not imply the use of any specific interventions; rather, it prioritises a continuum of support (see component 5 for a model of how to organise care into a spectrum ranging from community activities to specific service delivery). The community mobilizers should oversee all elements and ensure that the range of needs identified by the network is met.

Action planning by empowered community members

Action planning by empowered community members should result in activities for communities at large (see also component 5 for examples). This can be complicated, as members of the networks are all volunteers and activities must be decided upon democratically. Moreover, members of community-based networks at different levels will choose actions according to perceived need, available time and possibilities and in practice, meaning much of it will take place on an ad-hoc basis after the initial action planning initiated by CMs. However, at District level, overall planning and supervision according to predefined longer-term actions is needed. This should guide Village level networks to meet targets that have been defined at the beginning of a program.

Development of an action plan at district/provincial level

To develop an action plan at either of these levels, the Theory of Change (See Chapter 5 of this guide) can be elaborated upon. The objective of this exercise is to 'work backwards' from pre-defined long and short-term outcomes. This creates a conceptual map of how to create overall social change, meaning that it to those who are approaching the project from some distance, rather than on-the-ground participants. The first step is to reach a consensus regarding the ultimate impact on a community through the RMM approach; this impact is generally an ambitious visionary statement that stands for a healthy, thriving community.

Once the community mobilizers are familiar with the Theory of Change they can conduct the exercise with the members of the networks at district and/or provincial level in order to plan their actions. See annex 1 for a tool used in Theory of Change action planning workshops for community mobilizers.

Action plans on this level will be based on several principal axes:

- (Bi-)monthly meetings of these networks to identify priorities and actions to be undertaken by members of the networks (see component 2)
- Meeting with different stakeholders at different levels of society depending on identified priorities (CBOs, NGOs, local authorities, (private) organizations etc.) (see component 2)
- Conducting psycho-education sessions/workshops for members of the networks at community level, depending on needs (see component 5)
- In case of controversial issues, extra meetings/workshops at different levels of society with identified stakeholders to reach consensus about actions to be undertaken to reduce identified problems (see component 2)
- More specific interventions (depending on needs and existing resources, availability etc.) at the level of the community to find solutions for problems (see component 5)

6.10 *Component 4*

Capacity building of local stakeholders; ensuring the presence of human resources with appropriate personal, technical & organisational skills

Capacity building can serve to improve social cohesion and is a process of direct empowerment through cooperative participation by which people are invited to take responsibilities from the very start. Capacity building is an on-going process and should include:

- Organisational and leadership skills
- Management, accountability and leadership for organisations and community systems
- Service delivery
- Advocacy
- Networking
- Mediation
- Coordination
- Partnerships
- Testimonies

Depending on the purpose, network members can choose and combine capacity building trajectories. These include on-the-job training courses, classes/lectures on specific topics, learning from concrete cases or testimonies and Training of trainers (where individuals are fully

trained in a skill and how to pass this on to multiple others). Beneficiaries can also determine who they want to deliver training. CMs can facilitate this by getting in touch with experts in the relevant fields (NGO staff, government consultants, key informants from the community, professionals who part of the district-level network, etc.).

In practice, the capacity building of local stakeholders will take place at different stages of the implementation process, depending on needs, feasibility and chosen trajectories.

Using mechanisms for dissemination and diffusion: the Spiral Concept

A conceptual model for capacity building is based on the assumption that new knowledge, skills, and attitudes influence ever-larger circles of people within a community. An important assumption is that the participation and involvement of the community, families and local institutions and authorities (community systems) are what makes interventions effective and sustainable. This involves disseminating knowledge and skills throughout a society, rather than to individuals. The 'spiral model of capacity building' is used to reflect on some of the assumptions that go with this idea of dissemination:

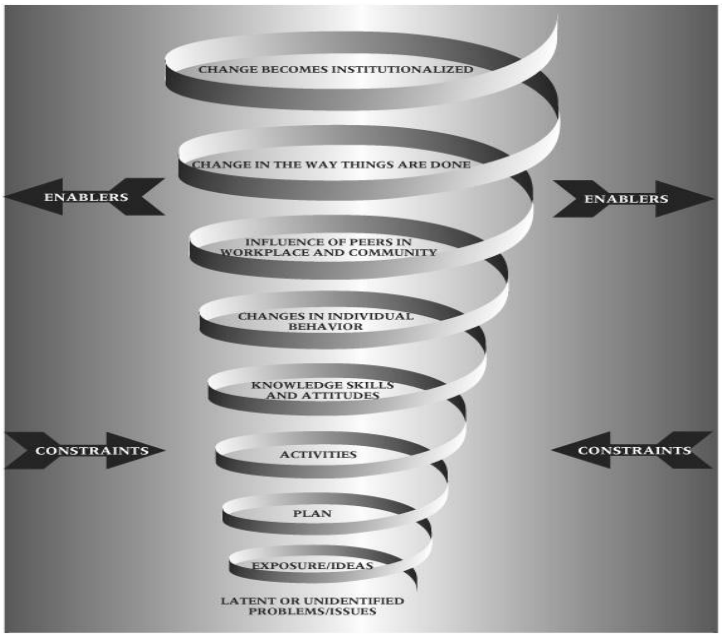


Figure 6: Spiral Model of Capacity Building[16]*(* Jackson and Kassam, 1998)

This concept is represented schematically in this figure. The figure shows a spiral in a box. The spiral is narrow at the bottom and becomes wider as it winds upward. At the bottom of the scheme is the initial exposure to problems and ideas. As the ideas are discussed, they generate enough support to be transformed into a plan of action. Contained in this plan are one or more activities. The activities of a capacity-building process may bring together groups of people who can affect the desired changes with those organizing the activity. Once in contact, existing knowledge, skills, and attitudes are sharpened and new knowledge, skills, and attitudes are acquired.

[16]Jackson and Kassam (1998) *Knowledge shared: participatory evaluation in development cooperation*. International Research Development Centre: Ottawa.

From this point on, changes in knowledge, skills, and attitudes begin to affect ever-widening circles of people, leading to corresponding changes in individual behaviour. Changes in behaviour, exhibited by the persons directly involved in the activity, influence changes in their own immediate workplace or community settings. This leads to concrete changes in the way things are done. Others start to notice the changes and, if they like them, support the new ways of doing things. Indeed, this level of support increases to a point where the changes become institutionalized—a part of the way things are usually done. Herein lay the seeds of sustainability.

6.11 *Component 5*

Community activities implemented by empowered key figures and/or referral towards a more specific service delivery

The next step is for empowered figures to implement the community's planned activities, which The next step is for empowered figures to implement the community's planned activities, which are geared towards their own definitions of health and wellbeing. These activities can be seen as *primary prevention strategies* against health-related problems (including reproductive and mental health) and other problems that affect well-being. They act as protective factors against illness, building awareness, social cohesion, and overall resilience. They are based in the community and focus on civil driven initiatives (see below for examples). For community members to be mobilized and able to carry this out, however, it is necessary for their own health needs to be met. This may well require *specific service delivery* from trained professionals and a functional system of referral to maximize access to these services. The following two subsections describe i) the preventative RMM interventions *based in the community* and ii) the way that RMM activities link with more *specialized service providers* to increase access to services and care.

Interventions based in the community

Empowered community members, who have been mobilized to act as responsible agents play a key role in planning community-based activities. These aim to improve wellbeing on a holistic level without the need for medically trained staff or psychiatrists. They may cover a range of goals and dynamics: for example, projects that aim to reduce gender-based violence, to promote family planning and the use of modern contraceptives, health associations or health insurance systems, and group interventions that target specific groups (socio-therapy, livelihood or income generating activities).

The following activities/interventions are examples of interventions, which can be implemented at the community level by local actors once their capacity has been build.

Awareness-raising. People are *informed* about the causes and consequences of problems and possible coping styles. For many people this basic information is a first and essential step towards a behavioural change.

Psycho-education. People (individuals or groups) are *educated* in the causes of medical, psychological and social problems that contribute to or are the result of PH and SRH related problems, normalizing their reactions to distress and providing coping skills to deal with adversity. Psychoeducation as public education is a community intervention with a potential to reach large numbers of people. Information can be disseminated on several issues (family

planning, alcohol and drug use, child rearing and children's problems, (domestic)violence, styles of communication, SRH issues and referral possibilities) that will help them to cope with their situation. Psycho education sessions can take place under the guidance of community mobilizers, but local actors can take over this responsibility as time evolves. Within the context of the SRHR project in Burundi the so called *"Community based Change Agents"* play an important role in the dissemination of key messages. Most of the time, these people are participants of the community-based networks and underwent a behavioural change as the result of RMM related activities. By telling their story before a larger audience, their testimonies become clear examples for other community members. Other important group that has been involved in the dissemination of key messages about SRH related issues are the *peer educators* that reach adolescent in schools or youth clubs.

Making use of local and mass media. Local and mass media can be mobilized to heighten public awareness about types of behaviour that are not well known or understood, such as the consequences of having many children, abuse of physically or mentally disabled individuals, the relation between specific physical disorders and psychosocial/MH problems (post- natal depression, post- partum psychosis, stress related complaints as a result of SGBV or domestic violence, and the relation between drug abuse and (SGB) violence).

Group discussions/support groups (for men, women or peer groups). People with similar problems or concerns come together to tell their story or discuss a problem with the specific aim to receive support or learn from other participants. Here, a community mobilizer has an important role (initially overseeing the process) but the group can ultimately become an independent self-help group. Members of support groups can be easily detected through the established RMM groups. Within the current SRHR project, different support groups have been established. Besides groups for victims of SGBV, young mothers, youth at risk (mixed groups), men groups were organized to discuss their behavioural patterns and the underlying motivations.

Socio therapy: Since 2013 Socio-therapy has become a key intervention for the SRHR project. Research and experiences of socio-therapy since 2010 has convinced the co-founders of C4C that it is a vital element of complex health-related interventions[17]and more in-depth research in the impact of this intervention is currently in process. The aim within socio-therapy is not to assist individuals with severe psychological or psychiatric problems but to increase the self-supporting capacity among groups of people and to improve general feelings of safety, trust, care and respect; a major purpose is to break the vicious circle of violence. Socio therapy encourages people to participate in social interactions and uses the group as a therapeutic medium; during group sessions where some 12 people come together once a week, participants are invited to share and discuss their problems and (internal and external) conflicts over a period of 15 weeks. Once the socio therapy sessions are over, participants are encouraged to continue as an independent 'self-help group' and to use their knowledge, efforts and network to discuss/solve practical problems or generate income.

[17] Annemiek Richter, Théoneste Rutayisire, Theophile Sewimfura, Emmanuel Ngendahayo, 2010 "Psychotrauma, Healing and Reconciliation in Rwanda- The contribution of Community-based Sociotherapy", *African Journal of Traumatic Stress* Vol 1 No.2 December 2010, pp 55-63.

Identification and referral of people in need of individual care and/or support. In Burundi the detection of victims of SGBV is taking place through the so called Gender Based Violence, Information Management System (GBV IMS), a standardized tool that the Government on Burundi is introducing and that permits to detect all forms of SGBV and the characteristics of the perpetrators (age, profession, moment/location of the event etc.) Within the context of the SRHR project, local actors that participate in the community-based networks have been identified in order to facilitate the identification of both survivors and perpetrators of SGBV. These so called "Braves" are mostly (female) survivors of SGBV; they live in the target area and are therefore trusted by victims of SGBV. After a first identification of survivors of SGBV with the help of the GBV IMS tool, the Braves make use of the so called Community Identification and Detection Tool (CIDT) that has been developed by the co-founders of C4C through PRIME[18] (and adapted to the local context). The CIDT is a tool that permits to i) identify people with moderate to severe psychosocial problems that are at risk to develop serious mental health problems ii) analyse if the problems identified have a serious impact on the normal and daily functioning of that person iii) if that person needs and is willing to receive support from mental health professionals. The Braves bring people that respond positively to these three criteria in contact with counsellors of other service providers.

From RMM to a more specific service delivery

Within the RMM approach, the planned support system can lead to a wide range of actions, not only in the field of primary prevention, but also related to the general (secondary) and specific (tertiary) levels of interventions. The establishment of networks (see component 2) is a precondition to make the referral to and collaboration with different actors within the fields of health, education, reconciliation, economic development, security and human rights, possible and sustainable. Community networks can represent individuals and ensure that specialized services reach those that need them. They can also bolster the impact of these services by linking them to other relevant services and working with them to meet the community's needs.

Examples of RMM Networks working with specific services and programmes:

1. A health programme that helps victims of SGBV may fail to prevent the exclusion of these women in society. Victims may not report instances of violence because of the cultural notion that these women have lost their dignity and honour. Clinical staff should be able to recognise signs and symptoms that might be the result of sexual violence, while good communication skills may positively influence the response of specific target groups. Community meetings can reinforce public knowledge on abuse and can address potentially negative effects of cultural customs and beliefs, for instance, customs involving the social exclusion of raped women.
2. Providing good mother-and-childcare goes further than providing health care. It also requires that a child has access to clean drinking water, can go to school and acquires skills that are necessary to participate in that society. Linking with and referring to organisations such as

[18] PRIME is a Research Programme Consortium (RPC) led by the Centre for Public Mental Health at the University of Cape Town (South Africa), and funded by the UK government's Department for International Development (DFID). The main goals of PRIME is to develop a mental health care package that can be integrated within the (sub-)health post.

other NGOs, national bodies (ministries) and international bodies (UN or other international players) is an essential way to meet these broader needs.

3. Equipping health facilities with modern contraceptives is no insurance that the methods will be used. In Burundi for example many (young) people believe that using a condom spoils their semen and is a rejection of the woman in question. Furthermore, although the "morning after pill" should be available in health facilities at district level (according to the National policies and strategies), health care workers often refuse to distribute this pill as a result of their religious/moral believe systems, even in the case of rape. Discussions with and between different stakeholders involved in sexual and reproductive health are needed about how to inform and convince community actors of the additional value of using contraceptives, within the acceptable realms of socio-cultural standards.
4. A livelihoods micro-finance programme may fail to reach specific vulnerable groups (e.g. widows or families that live in very remote areas). By bringing people together at the very start of an intervention, people are invited to discuss the most effective and sustainable strategies to ensure that services are indeed reaching the most vulnerable. Some people may have no access to services as they live in more remote areas but there might be other reasons; conflicts between tribes or ethnic groups or inequalities between genders can play a major role. These factors must be addressed before such a programme can take effect.
5. Community-based psychosocial work is an effective strategy against SRH related problems, but more serious complaints may need to be addressed in a professional setting. Aside from medical care, specialized psychosocial interventions (counselling for victims of SBV, first follow up of young girls that are pregnant, youth friendly SRH services) can be delivered at the health facility level to meet the more severe needs of the community members. The establishment of a referral system facilitates community detection and improves access to care: Community Health Workers will take an active part in village networks, enabling non-professional people to identify people with SRH problems within the community and refer them to a health facility. The CIDT tool which has been developed by Culture 4 Change can be used for this purpose.

6.12 *Component 6*

Assessment, monitoring & evaluation, research

Assessment, Monitoring & Evaluation and (action) Research are important aspects of the action planning cycle; it enables the participants to reflect on the assess plans and action to ensure lessons learned and fed back into future planning. Assessment, M&E and research fall on a continuum of activities that are aimed at answering questions we can have about a set of activities. These questions cover: "Who is the target group that I need to target? What problem is most important for this target group? Have activities been implemented as intended? How do beneficiaries evaluate the activities? Did activities reach their intended goals?" Answering these questions is essential for designing a program, learning from experiences, and improving activities for future implementation.

Assessment and action research

The data collected through component 1 (mapping) can be considered as a baseline assessment and will result in a first definition of change and implementation strategy, based on priorities,

possibilities, available expertise and other context relevant issues. However, conducting an assessment should not be a one-off exercise and be seen as a continuous process of data collection. This can be seen as action research: an iterative process of a group action and reflection. An initial strategy can change as time evolves, according to lessons learned, feedback and to new and relevant data, information and knowledge. It is important that assessments and evaluations are shared between relevant stakeholders (as described in component 2) and that results are collated and disseminated to these relevant stakeholders.

Monitoring and evaluation

A fundamental element of all programming is a monitoring and evaluation (M&E) system, which should be set up in collaboration with the main implementers (coordinators and CMs). The most essential element of M&E is the formulation of clear objectives and indicators; in other words, knowing what success of a program would look like. Objectives refer to what the goals of a program are, and indicators refer to how the attainment of that goal can be recognized. Objectives can be formulated at different levels (UNICEF, 2008):

The first, most direct, level, and usually most simple to measure, are *output objectives*. These objectives are the immediate accomplishments of the project input. They often involve stating how many people will be trained or reached by services, and how much infrastructure has been set up.

There are also *outcome* objectives. These objectives refer to achieving more than just the 'roll out' of services; an actual change should be followed from service delivery. For instance, if an output objective aims at reaching a certain amount of people through awareness raising activities about SGBV, it would state that these awareness raising sessions have led to a significant increase in knowledge about how to reduce SGBV or the negative effects of early marriages amongst girls.

Within the context of the SRHR project, the monitoring on an outcome level takes place through so called Action Research that permits to monitor whether activities in the field correspond to ideas, predefined strategies and approaches. A process evaluation has been conducted in 2013 (See Annex 2) through qualitative interviews with recipients of support while assessing subjective beneficiary perspectives on the appropriateness of the overall RMM approach and different services provided. The process evaluation aims to answer to what degree the provided community-based approach (RMM) is appropriate to meet the needs of the beneficiary.

This initiative gets a follow up through the collection of data (with the help of the students of the University Lumière of Burundi) on a quarterly base regarding the perceived progress of the members of the different community structures (community based networks, support groups, socio therapy groups, Community Change Agents, peer educators) that have been established as a result of the RMM approach. At the same time data from the Ministry of health is collected at a regular base to determine progress on key indicators that have been defined at the beginning of the project and in accordance with the expected major outcomes of PNSR (National Strategic Plan 2013-2015).

Finally, there are *impact objectives*. These objectives state the broader change that the program strives to create. In RMM, these objectives often identify a psychological change (e.g. reinforced

adherence to FP methods and the use of MCMs, less ISTs, etc.) or a social change (e.g. increase in trust, more communal activities, less domestic and/or sexual violence). Continuing the above example, an impact objective would be that the SGBV is reduced, and that girls marry when they are older (above 20) and that this is associated with decreased emotional distress. The attainment of impact objectives often takes more effort to assess over a longer period.

There are different methods to measure the outcomes and impact of programs and using a combination of methods will be most informative. Quantitative and qualitative research methods differ primarily in their analytical objectives, the types of questions they pose, the types of data collection instruments they use, the forms of data they produce, and the degree of flexibility built into study design. The Global Fund offers a comprehensive tool for the M&E of RMM[19], which advocates developing both qualitative and quantitative indicators that are measured accordingly. It must be noted that this tool is based on the Global Fund programme to reduce Malaria, AIDS and TB and may well need to be adapted to suit the needs of an alternative programme. Nevertheless, it provides "a strong structure for collecting, analysing, understanding and communicating key information throughout the life of an intervention or program."

Research

Aside from the informal action research (described under 'assessment'), rigorous research on the RMM process should aim to identify the overall effects of the intervention and the mechanisms that underlie them. This protocol provides an *approach* to community mobilization interventions, which can be used for health promotion outcomes (as it is within Culture 4 Change). Ultimately, designing research into such complex, multi-level programmes is certainly a challenge, as demonstrated by the lack of high quality empirical studies on community mobilization in the literature review. Nevertheless, this is an important step for gaining a broader understanding of what works and how in community mobilization interventions for health and wellbeing.

Within the context of the SRHR project, a research has been foreseen will consist of a cluster Randomized Controlled Trial (RCT) to evaluate the efficacy of socio therapy

[19] PART 5 of the Global Fund Monitoring and Evaluation toolkit
http://www.theglobalfund.org/en/me/documents/toolkit/

7. References

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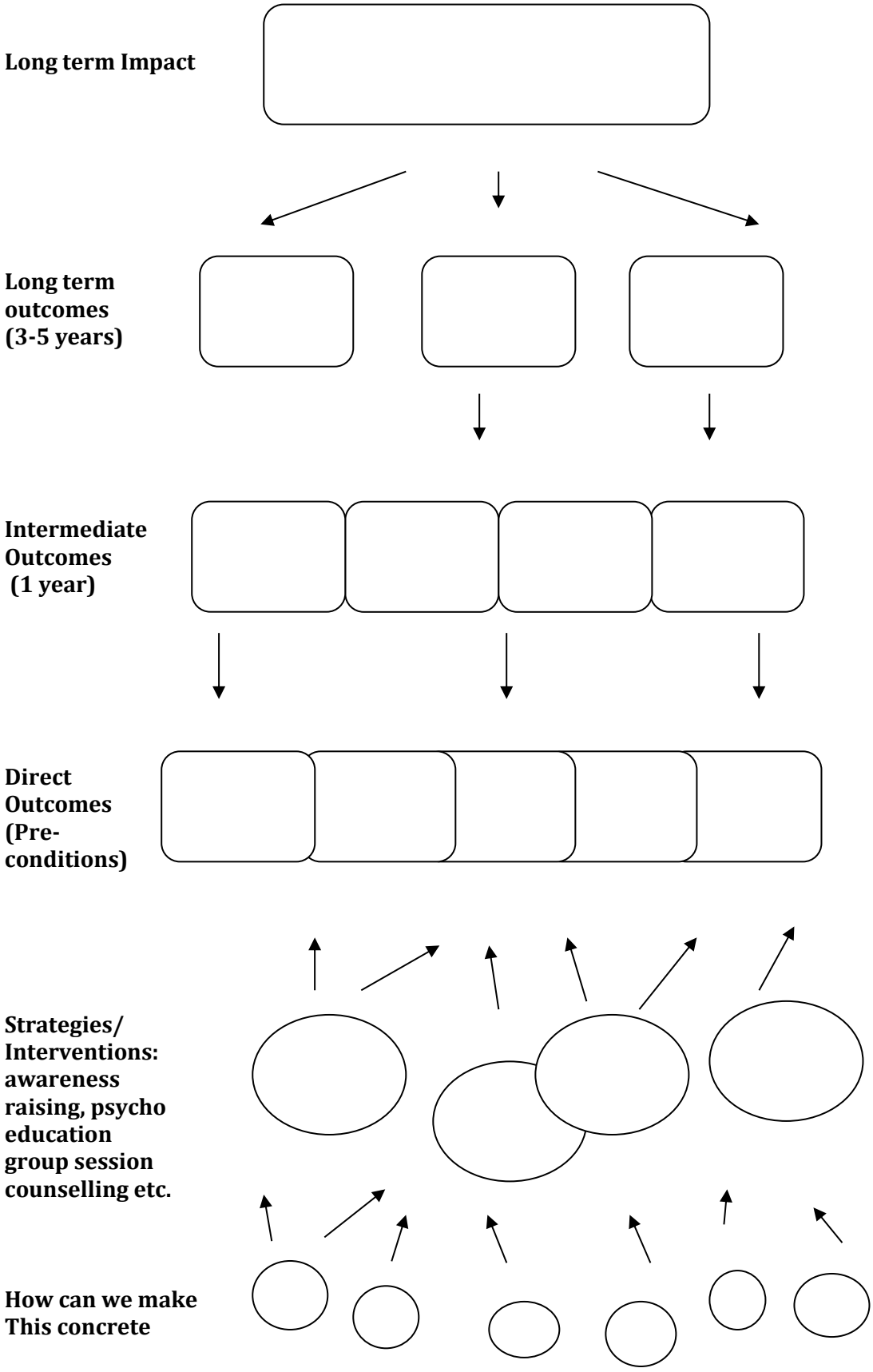
Annex 1 Outcome mapping: roadmap



Step 1: Clarify Goals. First, identify the ultimate impact you want to achieve in your community. The impact will generally be an ambitious visionary statement that stands for a healthy, thriving community – it's not about specific program clients or the results of a specific strategy. Your impact statement will involve the contributions of many strategies and partners. Examples of ultimate impacts follow:

- Children have equal opportunities to succeed in school.
- Children are healthy and safe.
- Families are strong and united.
- Neighbourhoods are strong and cohesive.
- All families and individuals have a roof overhead and food to eat.
- All families and individuals are self-sufficient.

List the ultimate impact in the **goal** rectangle at the top of the chart. It is important to develop a group consensus about this goal. Typically the statements are broad enough to make everyone feel comfortable, included and inspired. The distinction among impact statements is the level of focus (i.e., children, women, families, neighbourhoods or communities).

Step 2: Identify long-term (3-5 years) and intermediate (1 year) outcomes based on identified needs, priorities and resources (mapping reports)

Some examples

- Young men in target area are changing their behaviour (3-5 years outcome)
- Village leaders tackle the alcohol abuse in an effective way (3-5 years outcome)
- Relevant stakeholders at District and Community level create a network (1 year outcome)
- Women in target village know where to get help (1 year outcome)

Step 3: Create "In order to…it is necessary that' Chains' based on the following question: what are the preconditions for this goal/outcome. For example: "We want a reduction of violence in this community". In order to reach this goal it is necessary that……..Repeat this question until each outcome can be linked to a concrete strategy or activity

For example:

Reduction of violence in society (Impact]
In order to reach this goal t is necessary that ……

Women and girls are no longer sexually abused [Outcome]
In order to reach this outcome it is necessary that ….

(Young) men change their behaviour [Outcome]
In order to reach this outcome it is necessary that ….

(Young) men are confronted with their behaviour [Outcome]
In order to reach this outcome it is necessary that ….

The local population and authorities are willing to undertake action in order to address (sexual)violent behaviour against women [Outcome]
In order to reach this outcome it is necessary that ….

Local population and authorities receive awareness raising/psycho education sessions about causes, consequences of (sexual) violence and possible intervention strategies [Strategy 1]

We collaborate with local partners who work with ex-combatants [Strategy 2]

To make this concrete we have to:

1. Train our Community mobilizers
2. Organize awareness raising session for local population and authorities
3. Select venues and participants
4. Develop modules
5. Organize workshops for legal authorities
6. Organize an exchange workshop with local partners
7. Etc.

Step 4: Identify Powerful Strategies. Consider specific **strategies** or programs (that are currently in place as part of your partnership or develop new strategies) which address your outcomes. These strategies may include program strategies, campaigns, initiatives, collaborations, public awareness efforts, capacity-building efforts, community mobilization efforts and so on. Here are some examples:

- Establishing networks
- Case management services
- Media campaign
- Awareness raising session
- Psycho education (individual or in groups)
- Group work
- Leadership development
- Technical assistance
- Courses and workshops
- Advocacy
- Resource development and distribution

Rarely is one strategy alone sufficient to achieve community change. Some parallel strategies could be to launch a public awareness campaign to focus on the importance of child care quality in the selection of care or to advocate for increasing the health and safety standards for licensing requirements.
List your strategies in the ovals at the bottom of the chart.

Step 5: Test the Logic and Relevance. Review your completed map and share it with other stakeholders. Test whether logical linkages occur between the strategies, outcomes and impacts; whether the most relevant outcomes are included and whether you have included all of the relevant strategies. Based on these tests, revise, test and revise some more. It is typical for a Theory of Change outcome map to be revised several times before it provides a complete and clear picture of your community change effort.

Step 6: Articulate Assumptions. While the outcome map offers a visual sketch of the pathways to achieving outcomes, this work is embedded in a context. It is helpful to complete the story by articulating the assumptions that influenced the map's design.
There are no hard and fast rules about what to list in the assumptions. It is useful to provide narrative information about the principles and belief system that underlie the outcome map. Often these statements will be part of the discussion while you are constructing the map. It helps to

record the assumptions in an ongoing process while you are creating your map and to compile them once the map is complete.

> **TIP:** You can maintain an ongoing list of assumptions that emerge during your Theory of Change work on a flipchart page.

Here are some examples of assumptions:

- Our partnership is based on the belief that community members know best what is needed in our community.
- Effective partnerships are built upon trust, consensus and collective belief in a common purpose.
- Public policies should prioritize the well-being of children over other interests.
- Skill training is a critical factor in employment, but so are supportive communities and employer workplaces.

Annex 2 RMM process evaluation

Aims of a process evaluation:

Mapping the pathways between an intervention and it's desired outcome is an essential step in developing an evidence-based intervention approach (Campbell et al., 2007). Conducting a process evaluation is a good way to monitor whether activities in the field correspond to the conceptual model of RMM. Specifically, it aims to:

- Monitor the feasibility (logistics, organization, adequacy of support) of activities in a given context
- Identify any problems that are being encountered.
- Identify whether activities are relevant and useful to those involved in the process (levels of satisfaction and observed impacts of different stages).
- Highlight any gaps or problems of the conceptual model when it is applied in a given context, so that adjustments can be made to it.

A process evaluation is *not* a means to evaluate the ultimate outcome of the process (as the final outcomes are not actually measured), so should be seen as a preliminary stage before designing a full evaluation design of the program. This evaluation design cannot be predefined, as it depends on the way the community defines their indicators of wellbeing and on the way that activities/ interventions develop within a specific context. See the end of this section for recommendations for further research beyond the process evaluation.

Interview schedules and respondents:

Below is an example interview schedule for a process evaluation of the RMM model, presented in section 5 of this guide. This interview schedule was designed to be used for interviewing a relatively large sample of village and district level network members (i.e. it has been used in a study of approximately 200 respondents from of a set of 20 small villages in which RMM has been established when Culture 4 Change started to use the RMM the approach with the context of the SRHR project). For this reason, it consists mainly of quantitative questions so that analysis does not require too much time and resources. However, it is recommended that the tool is adapted to fit the sample: if only small samples are available, the focus should be on more in-depth (qualitative) questions.

Similarly, different groups of respondents can be included in the process evaluation (egg. Community mobilizers or members of the wider community that are not directly involved in activities), which means interviews must be made relevant to them. Consider their experience of RMM activities: how they might be affected by each stage, potential problems they may face as well as their literacy levels and any practical constraints they may have in participating (e.g. available time).

The key point about the interview schedule is that is must try to gather information about each building block of the process. The questions are designed to give an understanding of each individual stage, so that the findings are broken down into many components, rather than one overall "result".

Example Interview Schedule:

Process Evaluation Interview Schedule: Network-Member respondents

Topic	Question	Response
External engagement/ leadership	1. How much support do you feel you had from HNTPO project coordinators when you first started the project in your community?	1 – no support at all 2 – a little support 3 – a moderate amount of support 4 – a lot of support 5 – complete support
Training of community mobilizers	2. To what degree are you satisfied with the qualities of the community mobilizers? 3. Please state any areas you feel they need more training in.	1 - very unsatisfied 2 - unsatisfied 3 - moderately satisfied 4 - satisfied 5 - very satisfied ……..
Community mobilizers	4. To what extent do you feel that community mobilizers are there for you when you need their support?	1– not at all 2 – a little 3 – somewhat 4 – a lot 5 – completely
Community mapping	5. Aside from identifying community problems, what (if anything) have the mapping exercises achieved?	……..
Community mobilization	6. As a group, how *motivated* is your community network to make your plan of action a reality? 7. How *feasible* is it for you to make your plan of action a reality (given your budget, resources, available support etc.)? 8. How useful has your plan of action been in helping you to make changes in your community?	1 - not at all motivated 2 - slightly motivated 3 - moderately motivated 4 – very motivated 5 – extremely motivated 1 – Not at all feasible 2 – slightly feasible 3 – moderately feasible 4 – very feasible 5 – extremely feasible 1 – Not at all useful 2 – not very useful 3 – moderately useful 4 – very useful 5 – extremely useful
Creating networks (community/ colline level)	9. How would you describe your role in the network? Please state whether you feel this role is clear to you and others. 10. To what extent do you think that the network is inclusive to different people in the community?	…… 1 – completely exclusive 2 – slightly exclusive 3 – moderately inclusive 4 – slightly inclusive 5 – extremely inclusive

	11. To what extent do you think the network will continue in the future?	1 – It will certainly not continue in the future 2 – it might not continue 3 – don't know if it will continue 4 – it might continue 5 – it will certainly continue
Creating networks (district /commune level)	12. Do you think the frequency of meetings between district level representatives is sufficient? 13. In your opinion, how much of an impact do these meetings have on reducing problems at a community level?	Yes No 1 – No impact at all 2 – a slight impact 3 – a moderate impact 4 – a big impact 5 – an extremely big impact
Availability of responsible agents of change	14. To what extent do you think people are *willing* to bring about the necessary changes in your community? 15. How much do you think these people are *able* to bring about the necessary changes in your community?	1 – Not at all willing 2 – slightly willing 3 – moderately willing 4 – very willing 5 – extremely willing 1 – Not at all able 2 – slightly able 3 – moderately able 4 – very able 5 – extremely able
Sense of future perspective/ hope	16. Has becoming part of your network made you think more or less positively about the future?	More positively Less positively Neither more nor less positively
Networks/ social connectedness	17. How has being part of the community network affected the relationships between its members?	1 – very negative effect 2 – slightly negative effect 3 – neutral or no effect 4 – slightly positive effect 5 – very positive effect
Theory of Change / Ability of community to make an action plan	18. Do you have a clear idea of how you want your community to be in 5 years' time? 19. If yes, do you know how to proceed, now that the network has been established? Please identify the next stage(s) in your action plan	Yes No ……
Capacity building for community members	20. How useful do you think the classes/ workshops you have taken part in will be for overcoming the community problems that you have identified? Nb Make it clear that these are problems the network identified in the MAPPING EXERCISES	1 – Not at all useful 2 – not very useful 3 – moderately useful 4 – very useful 5 – extremely useful
Co-ordination of inter-sectoral collaboration	21. Do you feel that your network is a heterogeneous group of people, representing different sectors (health, education, authorities etc.)	Yes No
Education/ capacity buildling	22. Following the capacity building workshops that took place in August/ September, have you organized any	Yes No

	training or support programmes that would benefit your community? 23. If yes, please specify	……
Community is willing and able to take (joint) action and make behavioral changes	24. Have you *personally* taken any action to help the network carry out its action plan? 25. Please specify any obstacles that have made it difficult/ impossible for you to help carry out the action plan 26. Has your network *collectively* taken any action in order to carry out its action plan? 27. Please specify any obstacles that have made it difficult/ impossible for the network to work together to carry out the action plan	Yes No …….. Yes No ……..
Functional system of referral to care services/local authorities	28. If people in your community come to you with problems that cannot be solved within the colline, how confident are you that you can refer them to a service or organization that is able to help them?	1- Not at all confident 2- Slightly confident 3- Moderately confident 4- Very confident 5- Extremely confident
Increased collective efficacy	29. Overall, what do you think is your network's biggest achievement since the beginning of the RMM project? 30. Who do you believe is responsible for this achievement? (If several people, please briefly describe their roles)	…….. ……..

Data analysis

As the interviews are designed to investigate individual parts of the process, questions should be analysed *separately* and not aggregated in to overall findings. This makes the analysis relatively simple, but researchers should be equipped with at least basic qualitative and quantitative research skills to ensure that valuable information is extracted from the data and presented clearly and accurately (ie familiarity with SPSS for quantitative analysis and ability to thematically analyze transcripts of unstructured responses)

Applications for the field and avenues for further research

As described in the aims of the process evaluation, the results have an immediate relevance to implementers of the RMM programme; they give an insight into perceptions and experiences of each stage, which can be used to fine-tune activities and address problems. It is recommended that the research team works closely with field workers such as community mobilizers, in data collection and in the follow-up of results to ensure maximum research uptake. A set of recommendations for the field should be drawn up as part of the presentation of findings and discussions with community mobilizers can help to determine the feasibility of carrying these recommendations out.

The second function of these findings is as a springboard for further research. As an immediate follow-up, there may be issues raised that require more in-depth discussion to resolve. For example, if several respondents flag-up problem(s) at a particular stage, focus group discussions could be set up to explore the problem and possible solutions.

The process evaluation can be followed up with further evaluation research on the RMM approach, which will investigate both its *mechanisms* (*how* it works) and its *efficacy* (*whether* it works). In order to establish underlying mechanisms, it is recommended that validated tools that have tested applicability in LMICs are used to measure particular stages of the model (for example, using the Adapted Social Capital Assessment Tool (A-SCAT, Harpham, Grant and Thomas, 2001) to measure "social connectedness"). Once these mechanisms have been established, ultimate outcome indicators must be defined. This requires careful consideration of the individual and group-level effects that RMM is hypothesized to have. Both the group-level outcome of "collective efficacy" and individual level outcomes of "community identified indicators of wellbeing" will have to be evaluated. This evaluation framework is currently being developed and will need to be adapted for context-specific research on individual programmes.

Main findings from a Process Evaluation of the RMM approach in Burundi:

Burundi 2013

Methods

A combination of quantitative and qualitative data was collected from stakeholders in the 3 Burundian provinces where the approach is being implemented at this very moment. The sample comprised of 3 groups: **Network Members** (N=168), **Community Mobilizers** (N=7) and **RMM coordinators** (N=3)

Main findings

- There is less commitment at the commune (district) level than the colline (village) level and there are issues with attendance. This is because members feel they need material compensation (in the form of fuel cost or resources) for their energy and expertise
- All networks were seen by network members to be highly inclusive although mobilizers report an absence of Batwa people and traditional healers in networks.
- Putting ideas into practice is difficult and feasibility problems tended to cluster in stages around and after the action planning stage.
- The Community Mobilizers displayed confidence in the progress of the project and in their own abilities to lead it but they stress the importance of training and capacity building activities (both for network members and themselves)
- Overall, the data substantiates the conceptual model: although some steps need fine-tuning and further research, no element was found to be absent, unacceptable or entirely unfeasible in the field.

Recommendations

- Implement further training for Community Mobilizers in identified areas (eg sexual and reproductive health)
- Follow-up action planning workshops: Respondents had a clear idea of goals but were less clear on their planned steps to reach them.
- Provincial level network formation (an important step that has not yet been implemented)

Annex 3 RMM and Mental Health/Psychosocial care

The co-founders of Culture 4 Change have a background in Mental Health (MH) and Psychosocial Support (PS), which has informed the development of the RMM approach. Through the ongoing monitoring of MH and PS related interventions, we have found that that to reduce mental distress, it is essential to attend to the social determinants of (mental) health. RMM therefore plays a vital role in the promotion and reinforcement of psychosocial well-being and mental health.

First of all, the mapping exercises (component 1) facilitate the identification of psychosocial problems (domestic and gender-based violence, stress related complaints etc.) and their effects on individuals and groups within the community. They also help to distinguish the more severe mental disorders (epilepsy, (post-partum) psychosis, (post-natal) depression, severe anxiety etc.) from milder forms of distress. As these mapping exercises take place in close collaboration with the community, they can be used to raise the awareness among this population about both the existence and possible coping strategies to address these problems. For example, through maintaining spiritual wellbeing, and engaging in cultural and traditional practices and rituals (Somasundaram & Sivayokan, 2013)

Secondly, psychosocial problems may lead to the expression of mental disorders in people who have vulnerability for these diseases, such as children with disrupted nurturing, adolescents traumatized by war and violence, and women overburdened in the family or suffering from domestic violence and discrimination. Specific workshops (component 4; capacity building) for the members of the established networks (component 2) about psychosocial issues will allow members of the different networks to intervene directly. Members of the networks will be able to take certain measures according to their abilities and opportunities: mediation within or between families; basic counseling (listening and effective communication); awareness-raising of the population on the consequences of (S)GBV, alcoholism, violations of the rights of the child etc.; and the identification of those in need of specialized mental health care. Preventing and reducing psychosocial problems through RMM will therefore prevent or reduce the expression of mental disorders. Within the mental health care framework used in RMM (see figure below), these are the primary level interventions, which benefit the widest range of community members.

Provided that trained staff are available, secondary levels of support can be provided to those with more specific needs. Community mobilizers who are familiar with mental health related issues and trained in providing focused psychosocial interventions deliver this support. These include group therapy, socio therapy, and basic counseling techniques. Examples of child focused support can be found in the first and second tiers of the Child Thematic Project.[20] These 'secondary' interventions are more focused but still based within the community.

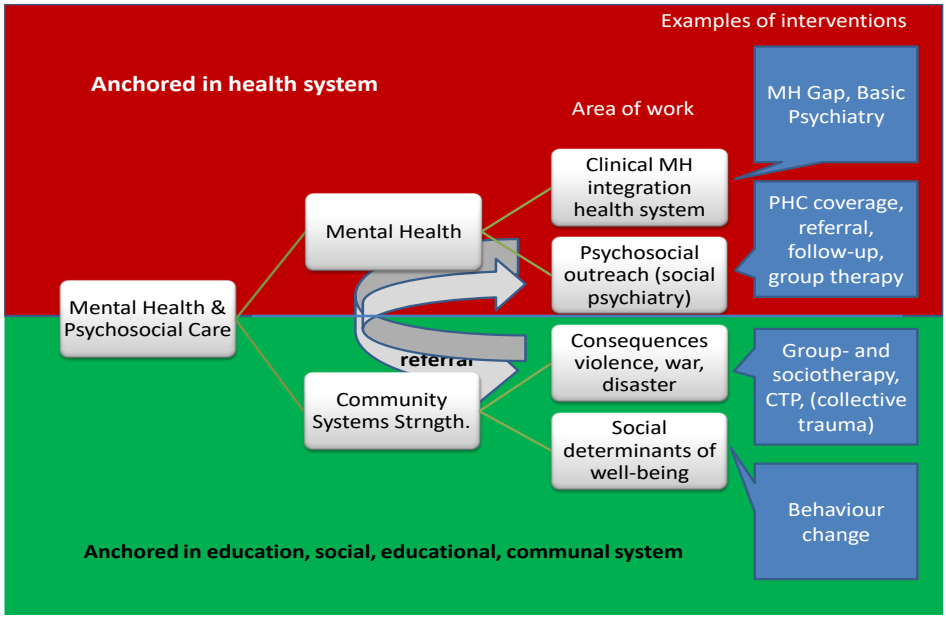
The tertiary interventions (group therapy; basic psychiatry) are anchored in the health system and must be carried out by mental health professionals, outside of the basic RMM activities. This is where a functional referral system (component 5) and strong links with the health services is essential. Ultimately, the broad based primary interventions will ease the burden of mental illness

[20] http://www.healthnettpo.org/en/1128/child-thematic-project.html

at the health facility level, so that particularly vulnerable or severely ill patients have access to the care they need.

See the figure below as an illustration of how RMM activities interact with mental health care at health facility level.

Mental health, Psychosocial Care/Support and Community Systems Strengthening



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