Six Guiding Principles of Streamlining
Community-based Programs

by Peter Gottert

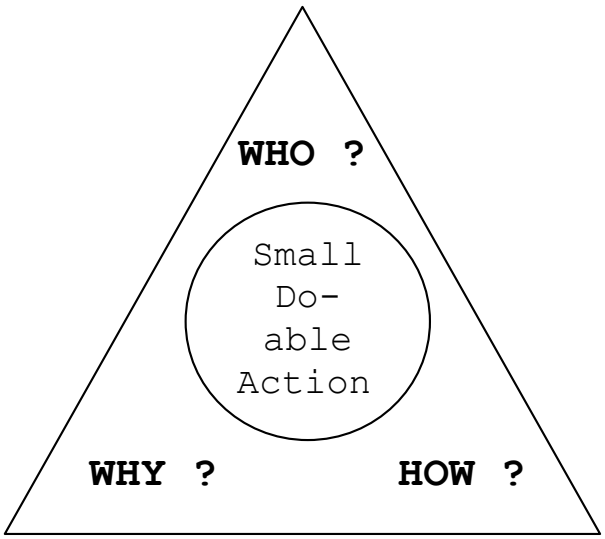
Six years ago in Madagascar, an MOH/BASICS team set out to design a community-based IMCI program that would be participatory in nature, yet streamlined enough to be rapidly implemented and taken to scale. During each step of the design process the team asked itself, « What is the simplest approach ? » « What can most easily be understood and acted upon by local leaders ? »

Following an 18-month pilot-program in two districts and an evaluation which demonstrated significant impact, the original design team reviewed each component of the strategy with groups of health agents, community leaders and members of local associations. A common thread ran through our lessons learned: *despite emphasis on streamlining, our community model repeatedly ran into difficulties because our approach remained too complicated.* Following mid-course corrections under the Jereo Salama Isika Project, managed by John Snow Inc. with the Academy for Educational development and The Futures Group, the community model has been taken to scale and is being successfully implemented in hundreds of localities.

Six guiding principles of streamlining community-based programs have emerged from our experience. When compared to standard health communications programs, we believe these principles save time and money without compromising quality. Time saved means quick start-ups and rapid rollouts, which translate directly into improved impact.

Principle #1: Action-based messages:

Harmonization and standardization of health, nutrition, family planning, STIs and AIDS messages by Madagascar's IEC Taskforce created a solid foundation for our program which in turn facilitated materials development and implementation. Each message is based on a small doable action - a recognized beneficial health behavior that can reasonably be implemented by rural families. Government and NGOs partners easily saw the advantages of eliminating knowledge-based messages in favor of those which promote action. The message guide which grew out this initial exercise insured that all health sector partners spoke the same language. This set the tone for continued, fruitful collaboration.



Once a do-able action (ex. breastfeeding during illness) is identified, pretesting the draft message becomes focused qualitative research, which allows program designers to identify motivational factors, and obstacles that influence parents. In addition to saving time and money, this approach keeps strategy development in the hands of local teams.

Principle #2: Develop easy-to-use front-line teaching tools: Our team chose counseling cards as the pivotal material in the communication strategy. Each card illustrates an essential behavior being carried out by a typical rural family. The cards focus all communication activity on promotion of these behaviors. The text on the reverse side of the card contains *only essential information that caretakers need* to carry out the proposed action - no more - no less. Pretesting the cards results in further streamlining - all excess text is cut.

We train health workers to use the counseling cards as front line teaching tools. By focusing communication on essential behaviors, the counseling cards save time - a key benefit which encourages their regular use. To strengthen program cohesion, community volunteers across all sectors use the same cards as the health agents.

As each set of cards is developed, production of second and third generation materials such as the lowcost g*azety* (a 2 cent newspaper which contains the same information as a set of counseling cards) or the family-friendly health card (16 cents) can be carried out rapidly. Total editions of some *gazety* are over the half million mark.

In subsequent programs, we have expanded on this idea of communication "basic building blocks." In our Ethiopia program, the Family Health Card (child's health record from birth - 60 months), the Woman's Card (covers three pregnancies plus HIV/AIDS) and the Youth Passport (HIV/AIDS related) as the fundamental tools. They are more comprehensive than counseling cards and valued more by the users. In Ethiopia when we have rolled out the family health card, just as in Madagascar we couldn't print them fast enough.

Principle #3: Short skill-based training in counseling and village theater: Training is a major area where an enormous amount of non-essential material can be eliminated. Again we follow a guiding principle: no knowledge-based messages, no knowledge-based training. Our skill-building workshops focus on two related communication techniques - use of counseling cards and village theater. Workshop programs are straight forward: practice, discuss lessons learned and respond to technical questions, practice again, further discussion and then.....more practice. Short 1 - 2 day workshops stretch the training budget and open the way to involve literally hundreds of community members in the process.

Each workshop launches between 5 -8 community groups. The key resource is crackerjack training teams to crank these workshops out. The workshops are the motor which allows a program to go to scale. There are no short cuts.

We encourage villagers to tap into grassroots creativity with drama. Village theater adds color, character and humor to a community education program. People often need examples of how recommended health actions are actually carried out. Theater is the perfect medium for addressing concerns which prevent parents from adopting new behaviors. Drama's highly participatory nature promotes empowerment and sustainability because once a few simple techniques are learned a community group is given full creative freedom to express itself with respect to priority health issues. To be successful, village theater should be kept to 4 - 7 minutes per skit.

This model is very light on the monitoring and supervision side. We prefer to have the workshop participants come back together to share experiences, discuss obstacles, etc. In my experience the traditional cycle of a project is that once expansion begins, someone says "hey, how about supervision?" And suddenly everyone's concerned with supervision and the expansion stops.

Lesson Learned: Over an 18 month period, many village theater teams doubled in size due to local recruitment efforts. Most local groups continually improved the quality of their presentations by adding props, songs, music, and refining scenarios.

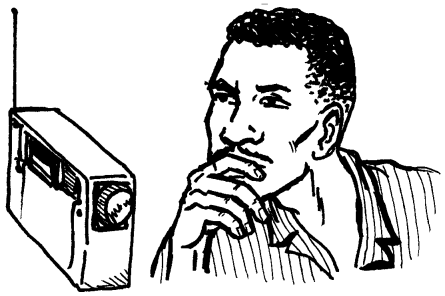
Principle #4: Engage large numbers of volunteers: This is central to scaling up. Our volunteers come from the dozens of *established* community groups that have are either already involved in health promotion or are eager to integrate health into their activities. Our goal is to respond positively to all groups interested in collaboration. Because we believe that a community program's impact is directly correlated to the number of volunteers active in the field, we budget to train up to 1% of the population – this means two thousand volunteers for a regional population of 200,000. Most programs engage only .025% or less of the population as community volunteers – not enough to reach critical mass.

Lesson learned: During Phase I roughly half the organizations we worked with were Village Animation Committees (CVAs) - groups created expressly to support project goals. The other half were functioning local civic groups, such as women's cooperatives, scouts or religious groups. Feedback from our field staff, indicated that a good CVA was more productive than other groups because they were 100% focused on project goals. However, the limited number of high-performance CVAs did not outweigh the considerably greater start up problems we encountered when launching CVAs.

Therefore, project staff decided to get completely out of the business of creating project specific groups by working with functioning community organizations which we believe offer greater opportunity for sustained development. Consider a Red Cross volunteer who has been active in her organization for eight years. The question of local ownership and indemnities was moot when we agreed to help leaders of her local chapter sharpen their health communication skills.

Lesson learned: Anticipate drop outs. We expect our volunteers will get tired and reduce the level of their activity by a half after twelve to eighteen months of sustained service. Again our response is straight forward, we train and launch three new volunteers before activities have a chance to drop off. Continually emphasizing expansion over consolidation, we believe, is the only way to engage a critical mass of volunteers necessary to bring about a large scale behavior shift.

Principle #5: Intensive mass media support: We are presently testing the hypothesis that a community program must have mass-media driving it in order to truly achieve scale. Otherwise the program dies under its own weight. It becomes too difficult to sustain enthusiasm and engagement over a large geographic area without mass-media. The backbone of our mass media program is the 45 second promotional spot. Why start with spots? Because they are quick and easy to produce and broadcast. In the same spirit we make low cost tools, such as the g*azety*, accessible to large numbers of families, we broadcast dozens of spots on over ten fm stations every day, day in and day out. With the spots working for us, we developed short rural radio programs by recording local skits and brief interviews with parents. Powerful synergy between two communication channels is achieved when village skits are broadcasting on local radio stations.



Principle #6: Celebrate achievement: When a mother completes the vaccination series before her child's first birthday the health worker capitalizes on this achievement by awarding her child a diploma. Similarly, the family planning invitation card has successfully catalyzed communication between regular users and their friends and neighbors. Thousands of small celebrations of achievement vastly enhance community spirit.

On the community level our annual festivals are joyous celebrations. In many ways a festival is a cheerful supervision visit which contributes tremendously to improving the quality of field activities. Festivals which follow four - six months of community health promotion, are end of the season parties, graduation ceremonies which promote an exchange of ideas and launch a new wave of activities. In every case, without exception, the population has exceeded our expectations. The creativity and pride displayed by village teams is exceptional. Each of the thirty or so health festivals we've helped organize cost less than $160.

Our initial community-based IMCI experience in Madagascar has provided our team with a rich harvest of practical lessons that we are presently plowing back into expanded Phase II activities. We feel that the Madagascar community communications model demonstrates that streamlining opens the way for rapid rollout, greater participation and ownership which in turn contributes to improved program impact.