

Community Group Engagement

What is the promising high-impact practice in family planning for social and behavior change?

Engage and mobilize communities in group dialogue and action to promote healthy sexual relationships.

Background

This brief describes the evidence on and experience with community group engagement (CGE) interventions that aim to foster healthy sexual and reproductive health (SRH) behaviors. The distinguishing characteristic of CGE interventions from other social and behavior change (SBC) interventions is that they work with and through community groups to influence individual behaviors and/or social norms rather than shifting behavior by targeting individuals alone. Specifically, community support can shift individual behaviors, including contraceptive behaviors, either by changing norms or individual knowledge and attitudes (Storey et al., 2011).

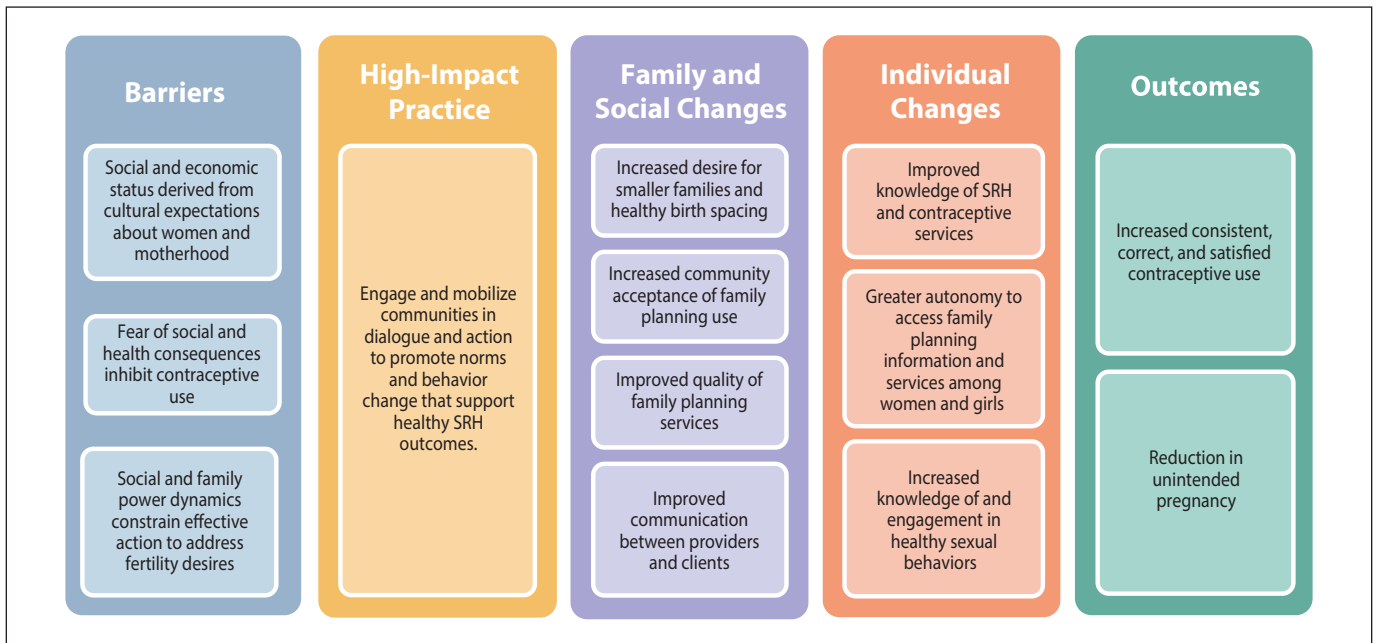


Save the Children, 2002

Individuals face many barriers to accessing and using contraceptives effectively, such as a fear of social and/or health consequences of using family planning. The barriers included in the illustrative theory of change for CGE shown in Figure 1 are based on a review of gender barriers to contraceptive use (McCleary-Sills et al., 2012) and reflect common issues addressed by CGE activities. Although the theory of change is set up in a linear, unidirectional format, it is likely that the mechanisms of action are multidirectional and more complex.

Community group engagement activities typically follow a defined process to identify and respond to perceived local drivers of and barriers to sexual and reproductive health. This approach seeks to maximize broad engagement and to move beyond conversations with decision makers and leaders to better understand sexual and reproductive health from the perspective of the community. Activities may include mapping exercises, social network approaches, exploratory games, dramas, case studies, prioritization exercises, and coalition-building, to name a few. Although activities may be facilitated by outsiders, such as NGO staff, public servants, or extension workers, they rely on active participation of local community groups and members to catalyze change.

Figure 1. Promoting Positive SRH Behaviors by Engaging and Mobilizing Communities: Theory of Change



Programs frequently implement CGE interventions as part of a package of interventions to influence the individual, family and/or peer group, and community simultaneously. Community group engagement should be linked with other SBC approaches (e.g., mass media, interpersonal communication, or counseling) and/or investments in service delivery improvement for greater impact.

Community group engagement interventions are one of several promising “high-impact practices in family planning” (HIPs) identified by a technical advisory group of international experts. A promising practice is one that has good evidence but more information is needed to fully document implementation experience and potential impact. The technical advisory group recommends that these interventions be promoted widely, provided they are implemented within the context of research and are carefully evaluated in terms of impact and process (HIPs, 2015). For more information about HIPs, see <http://www.fphighimpactpractices.org/about>.

Which challenges can community group engagement help countries address?

Women and girls derive social and economic status by conforming to cultural expectations about womanhood and motherhood. (McCleary-Sills et al., 2012). Gender norms that idealize sexual ignorance for girls and sexual prowess for boys are found globally (Kågesten et al., 2016; Marston and King, 2006). These norms underpin harmful social practices that contribute to poor health. For women and girls, these norms contribute to early marriage, social isolation, lack of power, limited mobility, and pressures to prove fertility by becoming pregnant early and often (Adams et al., 2013; Greene et al., 2014; Singh et al., 2014; McCleary-Sills et al., 2012), and are reinforced through family and community. For example, child marriage is typically a decision made by parents, spouses, in-laws, and other gatekeepers (WHO, 2009; Daniel et al., 2008; Mathur et al., 2004; Shattuck et al., 2011). Providers support these practices by placing age or parity restrictions on contraceptive access or by requiring spousal consent (Chandra-Mouli et al., 2014, Tumlinson et al., 2015).

Studies show that CGE can improve both men's and women's SRH knowledge (Schuler et al., 2015).

Limited knowledge and understanding of contraception and reproduction contribute to fear of the potential social and health consequences of using family planning. (McCleary-Sills et al., 2012). In many communities there is a general lack of understanding of the intersection between sex, reproduction, and contraception. Lacking such an understanding, women—and especially adolescent girls—may not effectively assess their pregnancy risk (McCleary-Sills et al., 2012, Sedgh et al., 2007).

Community group engagement can improve women's decision-making power. Women's ability to make and act on decisions is linked to contraceptive use (Chandra-Mouli et al., 2013; Kraft et al., 2014; Radice, 2014; Wang et al., 2013; WHO, 2010). Decision-making autonomy and ready access to or control over cash is critical to accessing contraceptive services (Miller et al., 2002; Keele et al., 2005). Analysis of Demographic and Health Survey data from 31 countries found that women with greater involvement in household decision-making were 80% more likely to be using modern contraception than those with no decision-making power. Women's involvement included decisions about their own health care, purchases of large household items or daily household needs, visits to their family or relatives, and daily meal preparation (Ahmed et al., 2010). Studies confirm that CGE can promote equitable gender norms and couple decision-making, and reduce acceptance of intimate partner violence (Schuler et al., 2015; Abramsky et al., 2014; Shattuck et al., 2011; Figueroa et al., 2016; Underwood et al., 2011).

Community group engagement likely influences change at the community, family, and individual levels by building capacity within the community. A study in Zambia demonstrated that CGE could improve social cohesion, collective ability to solve problems, conflict management, equitable and effective leadership, and participation/self-efficacy (Underwood et al., 2013). Individuals from communities that worked together to address health problems were over twice as likely to be currently using a modern contraceptive method than individuals from communities that did not work together to address health problems.

What is the impact?

Community group engagement is associated with higher levels of contraceptive use. In family planning programming, CGE is often used in combination with other SBC strategies and service delivery improvements. Studies using multivariate analysis of this combined approach have been conducted in Benin, Ghana, Nigeria, and Senegal. Multivariate analysis allows researchers to assess the relationship between exposure to CGE and outcome measures, controlling for exposure to other intervention components. All four of these studies reported an increase in modern contraceptive use or a decline in fertility rates after two to three years of program implementation (Speizer and Lance, 2016; Debpuur et al., 2002; Population Council, 2012; Ashburn et al., 2016). The impact of implementing the comprehensive programs varied from an increase of 4 to 10 percentage points in modern contraceptive use in the intervention communities (Speizer and Lance, 2016; Debpuur et al., 2002; Ashburn et al., 2016). Multivariate analyses found that in all four countries CGE contributed significantly to the observed results (Speizer and Lance, 2016; Debpuur et al., 2002; Ashburn et al., 2016).

Intervention designs varied substantially between the programs. Programs in Ghana, Nigeria, and Senegal emphasized activities working with religious or community leaders as well as the community at large (e.g., drama with group discussion), and they incorporated specific messages and activities. All programs, except the program in Ghana, included investments in mass media as well as other SBC strategies, such as print material. In addition, all programs, except the program in Benin, included improvements in service delivery (Speizer and Lance, 2016; Debpuur et al., 2002; Ashburn et al., 2016).

Studies of CGE have been conducted in varied contexts among a wide range of population groups. For example, participatory theater, songs, and large mixed-group dialogue were used to explore barriers to accessing family planning in crisis settings in Chad, Democratic Republic of the Congo, Djibouti, Mali, and Pakistan. Programs across these five countries supported 52,616 new modern contraceptive users over two and a half years (Curry et al., 2015). In Kenya, 150 trained community-based facilitators held ongoing community dialogues with men and women about gender, sexuality, and family planning over three and a half years. Women who participated in these dialogues were nearly 80% more likely to be using modern contraceptives at endline compared with women who did not participate in dialogues (Weg et al., 2016). CGE is also a common approach for engaging men. In Malawi nearly 80% of men participating in a CGE program reported modern contraceptive use (Shattuck et al., 2011). Although studies of CGE in El Salvador and Guatemala demonstrated increased contraceptive use in comparison with the control groups, the differences were not statistically significant (Lundgren et al., 2005; Schuler et al., 2015).

What does CGE Look Like? An Example From Uganda

In Uganda, the Gender Roles, Equality, and Transformations (GREAT) Project supported participants to reflect on social expectations related to being a boy or girl and how these norms influence sexual decision making and access to services. The CGE component involved a set of tools and a radio serial drama to promote dialogue and learning between groups of adolescents (ages 10–19) and members of their communities. The process was designed to engage community members and leaders to reflect on community norms, identify key issues, and develop and execute a plan of action. (Ashburn et al., 2006).

Community group engagement may be a critical component of comprehensive adolescent SRH programming. Community group engagement can facilitate dialogue with influential individuals to identify and clarify values around adolescent marriage and childbearing and to address norms, myths, and misconceptions about adolescent sexuality (Dick and Chandra-Mouli, 2006; Daniel et al., 2008; Daniel and Nanda, 2012; Denno et al., 2015).

Eight studies of adolescent programs that included CGE were identified—three in India, two in Nepal, and one each in Burkina Faso, Bangladesh, and Uganda (Save the Children, 2009; Kanesathan et al., 2008; Mathur et al., 2004; ACQUIRE, 2008; Thiombiano et al., 2006; IRH, 2016; Santhya et al., 2008; Daniel and Nanda, 2012). None of these studies included analysis to assess the unique contribution of CGE. Four of the studies measured program effect on early marriage, with all four demonstrating a positive impact (Save the Children, 2009; Kanesathan et al., 2008; Mathur et al., 2004; ACQUIRE, 2008), which can contribute to better child and maternal outcomes. In Bangladesh, the mean age of marriage increased from 14.6 years to 15.4 years; in India, from 16 to 18; and in Nepal, from 14 to 16 (Save the Children, 2009; Kanesathan et al., 2008; ACQUIRE, 2008). Seven studies reported on contraceptive use among married adolescent women. The results overall are inconclusive, which is consistent with the findings from a review conducted by the World Health Organization (WHO, 2009). However, the three studies from India and the study in Uganda recorded large increases in modern contraceptive use—10 percentage points or higher (Daniel and Nanda, 2012; Santhya et al., 2008; IRH, 2016; Kanesathan et al., 2008). Two other studies recorded minimal or no increase in contraceptive use (ACQUIRE, 2008; Thiombiano et al., 2006). One study in Nepal reported a decrease in contraceptive use; however, this decrease was greater in control sites suggesting the intervention may have dampened the rate of decrease (Mathur et al., 2004).

These eight adolescent programs were similar to the combined approach described above—all programs incorporated a variety of SBC approaches and service delivery improvements. In terms of target age groups,

two programs in India and one in Nepal focused on married women younger than 20 years of age and their husbands (Daniel and Nanda, 2012; Santhya et al., 2008; ACQUIRE, 2008). The other programs included unmarried boys and girls between the ages of 10 to 24 in addition to married adolescents while the program in Burkina Faso did not report a target population group (Thiombiano et al., 2006).

Community group engagement has been implemented in other health areas at scale and cost-effectively.

Large-scale implementation of CGE in family planning programs is not yet common place. Evidence for application of CGE in maternal and child health programs, however, demonstrates that this approach can lead to “cost-effective sustained transformation to improve critical health behaviors” (Farnsworth et al., 2014; Prost et al., 2013).

How to do it: Tips from implementation experience

A group of experts convened to identify key components to successfully engaging communities in behavior change (Gumucio, 2001). The group emphasized focusing on outcomes beyond individual behavior to those related to social norms, policies, culture, and the supporting environment, recommended that:

- **Communication for social change should be empowering, horizontal (versus top-down), and biased toward local content and ownership, and it should give a voice to previously unheard community members.** Group dialogue, reflection, and tailored participatory activities can highlight the contribution of gender and other social norms to poor reproductive health outcomes. These approaches are also particularly useful for individuals with little power, such as adolescents and ethnic minorities. Community group engagement approaches may give marginalized groups a stronger collective voice and agency to affect health and social change for themselves, within their families, and across the larger community (Storey et al., 2011). Once local stakeholders and community members articulate and explore these dynamics, they are better equipped to develop and carry out contextually relevant strategies that enable social support for changing norms and improving SRH practices.
- **Communities should be their own change agents.** In addition to ensuring NGO staff understand how social norms shape their own behaviors, CGE interventions should support individual community members and the community as a whole, for example, by building capacity to lead group processes to promote informed decision-making and collective action (Cheetham, 2002; IAWG, 2007). Strengthening the capacity of local youth-led or youth-serving organizations is also recommended (Youth Health and Rights Coalition, 2011; IAWG, 2007). With increased capacity to identify and address problems that affect them and their community, these groups can tackle other issues as they arise.
- **Emphasis should shift from persuasion and information transmission from outside technical experts to dialogue, debate, and negotiation on issues that resonate with community members.** Community group engagement interventions should avoid predetermining solutions. Community group engagement facilitates a process through which communities identify root causes to problems and craft approaches to



A Focus Group Discussion with young men in rural Mwene-Ditu, East Kasai Province, Democratic Republic of Congo

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addressing these causes. Once the goal is clear, communities often benefit from flexibility to identify and implement their own localized responses. Such flexibility on the part of programs is likely to increase local ownership, capacity, and commitment to achieve and sustain the community's desired results.

CGE programs should also:

- **Reach young people, especially out-of-school youth.** A 2009 review of adolescent programming for SRH from the World Health Organization concluded that out-of-school SRH education sessions allow for more open, participatory discussions compared with in-school education. Community members or established organizations that already serve young people, such as the Scout and Guide movements, can carry out the education and dialogue sessions in a sustainable, culturally sensitive way. The review recommends combining these educational sessions with community mobilization activities.
- **Build on existing platforms whenever possible.** Community group engagement interventions should assess the extent to which existing community platforms and groups include active participation of marginalized and/or affected populations. Using existing social infrastructure—both formal and informal—encourages sustainability and improves the possibility of effective replication and scale-up. Forming new groups, on the other hand, is resource-intensive and requires more ongoing efforts to sustain. Programs should bear in mind, however, that the most vulnerable populations such as adolescents and ethnic minorities may not feel comfortable participating within existing groups. In this case, these vulnerable groups may need support to express themselves and claim their rights to participation. When new community platforms are required, programs should add time in work plans—typically an additional six months to one year—for community entry and organizing.
- **Layer and connect SBC approaches.** Experts believe CGE works best when implementers create linkages and feedback mechanisms between multiple SBC approaches (for example, interpersonal counseling, group dialogue, and radio programming with harmonized themes) working to achieve the same aim. SBC health strategies that work at multiple levels and that use multiple channels likely have greater coverage and increase impact (Arora et al., 2012). As with all multifaceted and complex approaches, loss of effectiveness and efficiency during scale-up should be factored into planning (Maclean, 2006). Interventions should be designed with a vision of how to plan and support expanded implementation of proven components.
- **Define monitoring and quality assurance mechanisms.** As with other program approaches, implementation monitoring is necessary to ensure effective programming. Strategies such as low-dose (1 hour or less), high-frequency (once a month) implementation and follow-up sessions for group facilitators to share experiences and solve problems are useful to ensure high-quality programming. Observation checklists (on paper or mobile devices) for supportive supervision of group facilitators are also useful.
- **Ensure political and resource commitment to CGE approaches.** Community group engagement approaches often take ministries of health out of their comfort zone, which may lead them to deprioritize this intervention during scale-up, especially in the context of staff and resource shortages. For example, the long-term evaluation of the Navrongo project in Ghana showed that effective expansion of the CGE intervention was not sustained during scale-up, and thus the project did not sustain reductions in pregnancies when operating at scale (Phillips et al., 2012). High-quality data, as well as human interest stories from a diverse set of stakeholders who have been engaged from the beginning, can help build commitment. Other lessons on how to build this commitment may be found in efforts to secure buy-in and stakeholder engagement for scaling up capacity-building interventions for youth, adults, and organizations (Diop et al., 2004; Daniel et al., [2013]; Mathur et al., 2004).

Priority Research Questions

1. Do CGE interventions influence key family planning outcomes among specific adolescent population groups, such as very young, married, or unmarried adolescents?
2. How is CGE implemented at scale and what are the associated costs?
3. What level/dose and coverage of CGE are sufficient to achieve sustained change in social norms and family planning behaviors?

Resources

Communication for Social Change: An Integrated Model for Measuring the Process and Its Outcomes provides a practical resource for community organizations, communication professionals, and social change activists working in development projects to assess the progress and the effects of their programs. Available from: <http://www.communicationforsocialchange.org/pdf/socialchange.pdf>

How to Mobilize Communities for Health and Social Change provides step-by-step guidance on how to use CGE to influence positive health behaviors. Available from: <http://sbccimplementationkits.org/demandrnmch/ikitresources/how-to-mobilize-communities-for-health-and-social-change-2/>

References

A complete list of references used in the preparation of this brief can be found at: <http://www.fphighimpactpractices.org/resources/community-engagement>

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