Ideas and Action:

Addressing the Social Factors that Influence Sexual and Reproductive Health

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Social Analysis & Action

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Acknowledgments

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Atlanta, December 2007

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Section One: Introduction to Social Analysis & Action

As development workers, we know that good health is a necessary condition for helping people rise from poverty. We also know that poverty, and the social disadvantages usually associated with it, profoundly influence people's ability to stay healthy. For those of us whose careers have been spent working in communities around the world, the relationship between poverty, power and poor health is painfully clear. But have we done enough to address that relationship in our health programming?

Much of our health work has sought to improve the availability of high-quality health information and services for poor women, men and young people. The thinking behind this approach was that good information and easily accessible services would enable people to make positive healthcare decisions and act upon them.

This approach has worked up to a point. Decades of government and NGO efforts in the areas of prevention, health promotion and healthcare provision

Josh Estey/CARE

have undoubtedly led to better health for many poor people. Yet the shortcomings of our efforts are equally evident. Many intended beneficiaries never receive services, while others do not make decisions that could keep them healthy, despite access to sound information and health centers offering high-quality services. In other places, extensive investments in capacity building have not resulted in sustained improvements in health service delivery.

I believe that most of CARE's projects in HIV and reproductive health focus only on medical services, or on knowledge of reproduction or infections. This is not wrong, but it is not the complete picture. By not addressing the other components of sexuality, we are denying [our project participants] information on what their sexual needs are and the different options they have to address them.

– female CARE staff member

This stark reality has caused many in the health sector to ask difficult questions. Why do the very best communication projects not bring about prolonged changes in people's behaviors? Why, after decades of investment in areas such as family planning, do usage rates remain low? Why do we sometimes see reversals in improvements in health facilities or community-based services after a development project has ended? Why do we fail to reach more people, particularly the poorest and most vulnerable, who we know face the greatest disease burden?

Many of us believe the answers to these questions can be found by exploring the complex relationship between social factors and poor health. The World Health Organization (WHO) calls these factors the **"social determinants of health."** In WHO's words, "The most powerful causes of poor health are the social conditions in which people live and work, referred to as the social determinants of health. Evidence shows that most of the global burden of disease and the bulk of health inequalities are caused by social determinants."[1]

Increasingly, leaders in international health and development are voicing the belief that we need a dual focus on both health as well as the broader societal issues that influence it. In the past several years, with renewed international commitment to eliminate poverty, there has also been renewed research to understand the relationships between underlying social factors, poverty and health status. This research reaffirms what we see in our daily work.

For example, we know that poor people usually run at least twice the risk of serious illness and premature death than those better off. We also know that

What are some of the key social factors that affect health?

- **Gender:** Consistent denial of rights or access for women through systems of widowhood, divorce, child marriage, education, land and inheritance rights, and interpersonal violence.
- **Age and agency:** Youth isolated or excluded from decision making or denied access to health, education or livelihood.
- **Sexuality:** Social norms that restrict sex education, reinforce vulnerability to coerced sex, stigmatize sex work, link women's virginity with identity or power, discriminate against sexual minorities or promote use of sexual violence.
- **Masculinity and machismo:** Social norms that promote aggression, violence and limited emotional expression among boys and men, and limit opportunities for access to reproductive health programs.
- **Power and race, caste, religion:** Stigma and discrimination based on group identity.

Maggie Steber/CARE

socially or economically disadvantaged people often face social, political and systemic discrimination that can compromise their ability to make positive health decisions.[2] From a rights-based perspective, such health differences "are not only unnecessary and avoidable, but in addition, are considered unfair and unjust."[3]

Yet, as health workers, what do we do with our increasing awareness that social factors have an overwhelming influence on health? How do we translate that awareness into improved programming with greater impact? For CARE, the answer lies in more "rights-based" approaches to health-program design and implementation. Across the organization, CARE is experimenting with rights-based programmatic approaches to address the range of social issues that influence good health. This deliberate experimentation process is driven by an organizational commitment to justice and the pursuit of more effective health programming. CARE believes that addressing social issues in conjunction with health-service and information provision will lead to sustained health improvements, improved community capacity to address inequities and broadened responsibility for ensuring health for all. In sum, we believe this approach has the potential to result in social transformation.

Social Analysis and Action: Equity and Effectiveness

Through this experimentation process, CARE has developed an approach called **"social analysis and action" (SAA)**, which seeks to address the social, economic and cultural factors that influence health. SAA is an approach for working with communities through regularly recurring dialogue to address how their social conditions perpetuate their health challenges. In this way, SAA seeks to enable communities to identify linkages between social factors and health and then determine how to address them. As a first step in this process, SAA encourages CARE staff to deeply question their own biases and behaviors that might contribute to or reduce social stigma, discrimination and social conditions. In this way, SAA suggests that for developmental change to take place, change must sometimes begin with the development worker.

Several years ago, CARE's Sexual and Reproductive Health (SRH) team began working with CARE colleagues and partners in-country to experiment with new approaches to addressing social factors. The team realized that sustained impact on health would not be possible without addressing the many social factors that affect it. Thus, as part of CARE's broader poverty-reduction efforts, the team began developing approaches for helping communities to identify and address the social contributors to poor SRH. With the help of the

Key Elements of Social Analysis and Action Processes

Within the CARE programming context, SAA could be seen as:

- The process of exploring the social component of well being in order to create community understanding of how health is shaped by socio-cultural and economic factors.
- An understanding of the social complexities that aid or impede the fight for good health within a programming context.
- Taking concrete steps to address health and social issues within a reflection-action cycle (this is the action part of social analysis).

Reproductive Health Trust Fund, the team implemented the **Innovations Projects** in Georgia, Malawi, Sierra Leone and Uganda with the expressed mandate to explore and document new ways of addressing SRH through a social lens. These efforts, along with other CARE projects, have been key engines for SAA experimentation, generating much of the knowledge and experience captured in this guide.

Developing and experimenting with SAA has not always been easy, for CARE staff or the communities with whom they have worked. Helping communities

There is a deliberate effort by stakeholders to dialogue and challenge communities on the SRH issues and the other socio-cultural challenges, like promotion of early marriages, ignoring defilement and fear of implementing the law.

– regional Innovations Project coordinator, Uganda

to acknowledge and address their social inequities challenges staff and stakeholders to think about health in a more integrated manner. Confronting social realities can also be a complex and contentious process, leading to clashes between powerful parties at the community level. Still, we have seen that taking on this challenge can provide us with critical information to enhance our programming:

- In **Malawi and Uganda**, team members developed new definitions for "vulnerability" that better reflected the realities of the communities with whom they worked.

- In **India**, CARE adapted participatory approaches to delve deeply into the cultural and sexual realities of truckers, revealing to team members a subculture they had not known existed.

CARE

- In **Sierra Leone**, the SAA process helped the team to tailor its activities to meet the specific SRH needs of youth, and to address deeply held cultural traditions that impact them.

In each of these countries, SAA helped CARE to respond to the community's complex realities, to focus on real rather than perceived needs, and to engage a wider range of stakeholders in project implementation. As a result, the projects were not only more **effective**, they were essentially more **equitable**.

The Innovations Project was confusing at first; we did not know if the project was under population, health or community development.

– project partner, Uganda

An Ideas and Action Book

We have called this document an "ideas and action" book to reflect the experimental nature of SAA, which is exploratory and based on the personal experiences of people in the project sites. Our hope is that the ideas in this book will encourage readers to become part of CARE's broader experimentation process, by sparking your own creativity to explore with project stakeholders the social issues that affect people's health status. Our aim with this book is not simply to contribute to a growing body of knowledge about social determinants of health, but to catalyze a growing body of programming that effectively addresses those determinants.

This publication, designed for CARE program planners and managers, explains SAA at both a conceptual and practical level. The three sections that follow include:

- **Process:** What is SAA? In this section, we further describe the concept of SAA and walk you through each stage of its potential implementation within a program cycle.
- **Case studies:** What has our experience been with SAA? This section presents brief case studies that give you a sense of CARE's SAA experience to date.
- **Tools:** How might we implement SAA? This section provides practical methodologies for integrating SAA into different stages of the project cycle.

Personal reflections are another important element of this document; you will find them included in Section Two. As you learn more about SAA, you will see how personal reflection is essential to its success. We have included two personal reflection essays written by CARE staff members who have been leaders in SAA experimentation, and we offer questions to stimulate your own reflection.

Note to Our Readers

Although this manual focuses primarily on health at the community level, SAA can, of course, be applied to broader development issues. So please share it with your colleagues. CARE's hope is that SAA will ultimately be applied across the organization and with our partners.

[1] WHO. Action on the SDH: Learning from previous experiences. (CSDH, March 2005)

[2] WHO. Solid Facts. 2003.

[3] Whitehead, Margaret, 1992. The Concepts and Principles of Equity in Health. International Journal of Health Services. 22:429-45.

Section Two: Social Analysis & Action in the Program Cycle

In order to frame SAA within the practical realities of project implementation, this section explains it in the context of the program cycle, a familiar and widely utilized framework for understanding how projects are designed, implemented and evaluated.

The diagram on this page illustrates how SAA can be integrated into the traditional, community-based program cycle through five basic steps:

- **Transform staff capacity:** This foundational step is intended to prepare staff to experiment with the SAA approach. Strengthening the ability of staff to self-reflect, communicate and facilitate is, in fact, the beginning of the social transformation. Thus, CARE's new addition to the program cycle reflects our commitment to stimulating personal change prior to doing so with communities.

- **Reflect with community:** This is the first step in building trust with communities and engaging them in exploring how social factors influence their health needs, in encouraging their voice and agency, in engaging the most marginalized or vulnerable, and in redefining the community's relationship with CARE as the outside facilitator.

- **Plan for action:** This step occurs when community members begin to consider how to actually address key social factors impacting their health, when they weigh both assets and challenges, manage conflict, and when they further exercise leadership by committing to address social realities and inequities.

- **Implement plans:** This occurs when CARE pools its resources with those of the community and continues to create space for dialogue, and when community members might initiate activities outside of the CARE project to address their needs.

- **Evaluate:** Evaluation takes place when CARE and the community use simple, effective and reflective methodologies to determine if transformation is taking place, when we look for anticipated and unanticipated social changes, and when CARE works with the community to readjust plans in light of emerging information and reflection.

Most readers will be familiar with these steps, and many of you know that this analysis–action–reflection cycle occurs many times throughout a program's timeframe, providing many opportunities for integrating SAA approaches into our work.

While our discussion of SAA in the program cycle starts from the earliest stages of project design, this does not suggest that you must wait for a new project before you begin to address the social determinants of health. SAA activities can be incorporated at any point in the program cycle, and the tools and case studies presented throughout this book provide examples of how that can be done. Like CARE Uganda, you may decide to use intense focus-group discussion to fully explore the needs of your potential beneficiaries at the start of the project. Or, during your project evaluation, you might decide to utilize the Most Significant Change" methodology, as did staff in Peru and Malawi. Or perhaps you will do both. The decision is yours to take, based on your available resources, the community's needs and the practical realities of project implementation.

SAA in the program cycle: What is the difference?

As each step of the project cycle is presented on the following pages, we include a box outlining how this step is different from the traditional project-cycle step. Why? Because we recognize that you probably have been exposed to a host of methodologies that borrow from participatory approaches, and you might find it hard to distinguish one from another. We would like to help you determine how SAA might complement what you already know about participatory approaches, so that you can build on and adapt your existing knowledge and skills to implement SAA.

Jaime Stewart/CARE

Step One: Transform Staff Capacity

This foundational step is perhaps the most crucial component of successful SAA approaches, because it prepares staff to involve communities in sensitive and sometimes difficult discussions about how social factors fuel their poor health. Communities might have never had these conversations before, and CARE staff might have never facilitated them. Thus, the stakes will likely be high for everyone involved.

How is this SAA step different from a traditional participatory preparation step?

Those engaged in participatory approaches with communities might already understand much of the foundational step: how our actions, as CARE staff, influence reactions from the community; how we need to be facilitators of community-driven processes and often need to take a supportive backseat to community discussion and action.

SAA can often present more extreme challenges than CARE staff have traditionally faced. When engaging issues that challenge social norms, our own staff need to be comfortable talking about sensitive and controversial issues. Part of becoming comfortable involves challenging ourselves about our assumptions, beliefs and attitudes, and being conscious of social norms that guide us as well as the larger society. We must also learn how to manage confrontation and how to dialogue across differences.

Facilitators need particularly strong communication, facilitation and challenging skills, as well as good conceptual skills to grasp the connections between issues. They need to be creative, on-their-feet thinkers who are prepared to go on a journey with the community, not limited by their knowledge or comfort.

One of SAA's basic assumptions is that social change begins with us. More specifically, SAA asks us to reflect on and challenge our own biases before we challenge a community's inequities and biases. For some, this will involve new learning. Others will find it a critical opportunity to unlearn assumptions and approaches that have been with us since we began our careers as development workers. Our experience is that, regardless of situation or position, most CARE staff members find that the opportunity for self-reflection enhances their effectiveness.

Susan Rae Ross/CARE

Attitudes and Skills to Support SAA

As CARE staff, we wield power and resources that can reinforce inequitable donor–beneficiary relationships. We often feel a sense of distance, even superiority, with respect to our beneficiaries, or target groups. Failure to recognize our social and economic position vis-à-vis the larger community might limit our ability to catalyze honest dialogue and subsequent action. We might not ask community members the right questions. Or, if community members sense that we judge or misunderstand them, they might not share their true thoughts and beliefs with us.

Thus, SAA requires facilitators to question their biases and attitudes that might entrench unequal power dynamics, and to question their assumptions and preconceived notions about the people they serve. In this way, SAA requires both staff and beneficiaries to adopt a reflective learning approach to their work, which takes into consideration the complex social realities that influence health. By being willing to explore and address our own realities, we take the first steps to implementing SAA.

Personal Reflection

How are you the same as the people in the community you are trying to serve? What challenges, problems, attitudes or beliefs do you share? How might these similarities help or hinder you from bringing about social change? And how are you different from them? Are you from a different religion, ethnicity, tribe or economic group? How do these differences help or hinder you from bringing about social change?

In addition to requiring a heightened awareness of personal attitudes, SAA also requires a sophisticated set of **communication and facilitation skills** to enable us to lead communities through sensitive social explorations. This type of dialogue might draw staff into difficult situations, such as a community discussing a social taboo for the first time or a marginalized person confronting

a community leader. In order to make these experiences beneficial rather than harmful, CARE staff need to have highly tuned skills that are honed in a variety of settings. SAA will only go as far as the readiness of communities and staff to tackle sensitive or divisive social issues. Knowing when to provoke a community and when to pull away is, therefore, a key facilitation skill.

Given the kind of capacity required, it is critical to take teams preparing to embark on SAA through some form of transformational learning exercise. Depending on staff capacity levels and available resources, this could be as simple as a personal reflection exercise or as intensive as an extended staff retreat. Whatever methods you use, the key is to prepare staff to create conditions within communities that build trust, reduce hierarchies and create an environment of self-reflection that will enable breakthrough dialogue to take place.

Thomas Barton/CARE

I used to give knowledge through lectures; now I know that lectures are not enough. I facilitate discussions rather than giving the answer myself. I can judge what the group knows and what they need to know.

– Innovations Project staff member, Georgia

In many ways, these preparatory exercises lay the foundation for further transformation. As staff members experiment with SAA, they will likely be challenged, and ultimately changed. The recorded self-reflection of CARE Malawi staff, captured below, powerfully illustrates the shifts in attitudes, behaviors, skills and relationships that occurred as a result of their experimentation with SAA.

Malawi Staff Self-Reflection: The Personal Impact of SAA Experimentation

- "We have changed from using terms like 'vulnerable' to more humane terms like 'the less-supported' when describing vulnerable people."
- Staff members have learned to be patient in allowing communities to drive the process, even in areas where they could have easily used their own ways. "We have learned that communities learn better by doing. They make mistakes and then, in this humbled state, are very ready to try alternatives."
- "Our neutrality has helped maintain group cohesion. There has been a lot of temptation to get involved in local conflicts. We have learned that these conflicts are best handled by the community itself."
- "As the project has unfolded, learning has been so exciting. Our levels of comfort in discussing SRH issues have improved immensely. Through informal rapport-building chats, for instance, we are learning what vocabulary to use in the community."
- "As we have worked with communities, our understanding of inequalities has improved. This, in turn, has enhanced our understanding of existing support systems at community level."

Some Issues to Consider When Preparing Staff for SAA

■ *What are the key challenges we will face as we prepare our staff?*

This type of transformational learning will not just involve "how-to" exercises; it is intended to prepare us to dig deep for answers, rather than rely on stock understandings, tools or skills. Staff members should understand that they are not necessarily being trained in a new methodology, but are being encouraged to approach their work with a more reflective, critical mindset, and stimulated to use everyday communication techniques to enable communities to critically self-reflect on how their social realities affect their health.

It may be puzzling that the preparation does not provide a series of lectures on precisely how to carry out SAA. It is critical to convey to staff members that most of us already possess many of the skills and attitudes SAA requires; they must simply be heightened and sharpened to enable us to be effective SAA facilitators.

The second potential challenge is that SAA requires staff to go on an exploratory journey with community members to determine how social factors affect their health. The destination of this journey is not necessarily preordained. Preparing staff to "lose control" – to experiment, to change approaches in the middle of an exercise, or to fail – is a critical component of psychologically preparing them to experiment with SAA.

Sarah Kambou/ICRW

They (Innovations Project staff) do what they say. They respond to our questions, they go to our funerals, they share our lives.

– community member, Malawi

■ *How do I identify staff with the capacity to undertake SAA?*

During hiring processes and performance reviews, we need to make a concerted effort to determine the suitability of potential staff members for facilitating SAA approaches. Yet the required attitudes and skills might not show up on a CV, résumé or performance-appraisal form. What are their attitudes toward gender, caste, class or ethnicity? Do they have critical thinking skills and the ability to facilitate intensive group processes? Can they comfortably shift from educator to animator to facilitator? Your existing hiring and review processes might not elicit this type of information. Yet it is critical to ensure that you have staff on board whose skills, abilities and behaviors enable communities to explore and address the social realities of poor health, rather than inhibiting them from doing so. New staff members might not be ready to dive into SAA immediately, but they need to show the potential to adapt to its requirements. Meanwhile, existing staff should be fully prepared before being deployed to lead SAA experimentation, regardless of their seniority or years of experience.

■ *Who should lead the preparation of staff?*

Preparing staff for SAA requires a highly experienced facilitator who possesses skills ranging from basic listening, dialoging and group management to catalyzing discussions about differences within communities. Furthermore, this master facilitator must have strong conceptual skills and be comfortable

leading discussions around gender, inequalities, community mobilization and participation. In that sense, she or he must be able to move fluidly between the theoretical concepts that underpin SAA and its practical application.

This trainer must also possess the same attributes as those people she or he is training. Utmost among these are creativity, critical thinking and empathy. The trainer must be able to envisage and empathize with situations staff face, which requires considerable field experience involving exploration and challenging at the community level.

■ *How can we help staff become comfortable leading sensitive discussions?*
Our experience is that giving staff the opportunity, including a safe space, to talk about sensitive SRH issues, such as sex or gender, is an excellent way to break silences and help staff lead public discussions. Providing structured loops of reflection and learning, action and experimentation will help staff members undertake the personal changes required to enable them to catalyze community change. At the end of this section, we offer a personal reflection from former CARE staff member Sarah Kambou, which speaks to the power of personal reflection in enabling staff members to confront their own discomforts and taboos and, in the process, become more effective, professional facilitators.

A recurring theme in this type of training is how to handle personal values, since staff members often worry that opening these up to questions suggests that their own values are wrong. This is far from the case. Staff members will, of course, come to community discussions with their own values and opinions, which they should feel comfortable sharing, where appropriate. As an external organization, we have a vital role to play in catalyzing public dialogue and reflection about values and their impact on health. While we cannot and should not deny that we, too, possess values and opinions, these cannot be imposed on community members if social change is going to be genuine and sustained. Indeed, any change in values or beliefs must ultimately emerge from within the community itself.

Sarah Kambou/ICRW

■ *How can we prepare staff to manage stakeholder expectations?*
On a practical level, staff members need to understand that SAA might challenge the expectations of key stakeholders, such as donors or community members, by requiring greater time or different processes in an effort to achieve better-targeted, high-impact results. In order to increase buy-in, CARE staff should be prepared to explain the benefits of SAA to these stakeholders, so that they can fully appreciate how it can improve project quality and impact.

Reality Check! "With so much staff turnover, I don't have the luxury of investing in 'transformational learning'."

The realities of your project and staff will determine the nature and extent of your SAA preparation. The following are some tips for making the process both practical and effective:

- Find a good local facilitator or trainer who can provide this support to your team over time.
- Develop a mentoring program so that senior staff can support new and upcoming staff.
- Set aside time and money in your implementation plan for staff training and reflection.
- Where feasible, purchase materials such as books and manuals, which staff can refer to over time.
- Be deliberate in your hiring; look for those intangible qualities that can make SAA a success.
- Utilize Friday afternoons or Saturday mornings (when productivity might not be high) for informal staff-reflection exercises.
- Look for ways to reward staff members who provide SAA leadership.
- Make staff development an integral and ongoing part of your project implementation, rather than a "once off" that might occur when a project starts.

Sarah Kambou/ICRW

The Power of Personal Reflection in Social Analysis

by Sarah Degnan Kambou,
International Center for Research on Women (ICRW)

Several years ago, I collaborated closely with staff of CARE Niger to design a regional HIV program to reduce the risk of HIV infection among transporters, migrant laborers and sex workers. One staff member who had considerable experience managing HIV activities in rural Niger was selected to direct the effort for CARE Niger. Together with his team, we conducted social analysis in several rural villages noted for seasonal migration and high HIV prevalence. We were interested in learning more about the factors that prompted migration in the first place, and that created such broad vulnerability to HIV. Naturally, we focused on gender dimensions, since statistics showed increasing rates of HIV among women remaining at home while their husbands migrated to neighboring countries.

While we were working in the field, I was so impressed with my counterpart's ability to raise and discuss culturally sensitive issues – such as sexual pleasure – during participatory exercises with community members. He spoke with such ease and confidence, tackling difficult topics like condom use within marriage, alternative pathways to sexual pleasure and the importance of intimacy in relationships. I observed that his straightforward manner worked equally well when speaking with men or women. I concluded that since he himself was comfortable with the issues, and delivered messages with a non-judgmental tone, his audience was made comfortable to explore these issues verbally. We learned so much from these community exercises on the role of gender and sexuality in creating vulnerability to HIV that I asked him how he managed to create such an open and supportive space for discussion. He explained to me the 'power of personal reflection.'

"While we were working in the field, I was so impressed with my counterpart's ability to raise and discuss culturally sensitive issues"

My colleague had discovered that his 'lived experience' – knowledge and know-how, lessons and learning from his personal life – was fundamental to the execution of his professional duties. He felt that this was particularly true since his work at CARE Niger centered on the AIDS epidemic, and prevention messages necessarily addressed sex and sexuality, gender roles and power dynamics. In order to mine all of the relevant material from his lived experience, my friend had begun to reflect systematically and methodically on his daily experiences: his beliefs and attitudes; his actions and reactions; his attempts to change his behavior; his interactions with family, friends and workmates. He soon realized that he was carrying a lot of subconscious 'baggage' about his experience with gender roles and power dynamics, his experience with sexual roles and sexual behavior, his fear about HIV and AIDS. As he began to understand and address his own issues about gender and sexuality and their link to HIV, he began to understand the importance of addressing gender and sexuality more directly in HIV-prevention messages. As his personal comfort grew with these issues, tensions lessened around gender and sexuality in his professional work. Gradually, he honed the content of his messages as well as his communication style to converse with people on gender and sexuality, using language and imagery and experience that they could relate to.

I learned a great deal from my colleague in Niger, and had an opportunity to adapt and apply that learning in other CARE settings through the Ford Foundation-funded Inner Spaces, Outer Faces Initiative (ISOFI), which was implemented in India and Vietnam. In ISOFI, we purposely built personal reflection into the project life-cycle, and we expanded the use of reflection to include group applications. Over the course of two years, CARE staff working on ISOFI activities carved out time from their busy schedules to reflect on immediate past activity, learning on gender and sexuality generated through project implementation, and thoughts on how to refine interventions to ensure that they are as responsive as possible to local contexts. This formalization of reflection and application proved successful in changing staff members' personal attitudes and practices, and in promoting organizational learning around gender and sexuality.

Step Two: Reflect with Community

Mobilizing communities and carrying out participatory baseline assessments have now become standard introductory steps in most development projects. By utilizing SAA, CARE staff can add value to baseline assessments by yielding key insights on barriers to positive health outcomes, or developing constructive new relationships. Yet CARE staff must be deliberate in their preparation for this process. SAA requires us to reflect on why we are holding community discussions, whom we engage in them and which issues we choose to tackle.

How is this SAA step different from the discussions and analysis step in traditional SRH projects?

SRH projects traditionally use a public-health approach, the aim of which is to reach the most people with information, goods or services. Projects addressing the social dimensions of SRH go beyond the idea of reaching the most people, to identifying those who are almost never reached – those who have been marginalized from mainstream society and thus bear the burden of poor health. In SAA, it is important to empower groups that experience discrimination or social exclusion, so they can express their voices and rights to health.

SAA also involves taking a broader perspective on these discussions. Social factors can be large-scale, such as conflict or global trade restrictions, or linked to government policies that ignore social realities. Or they can be local, such as harmful social customs or gender relations. Issues at all levels can be critical and are often interrelated.

The other difference is the type and amount of information that is collected. Traditional SRH projects focus analysis on knowledge, attitude, practice and service gaps. In SAA, we are also interested in social position and how it influences poor SRH. This also means that more information is collected and must be analyzed.

Why: SAA asks that you approach these early dialogues with a genuine willingness to uncover new issues or realities. Because of their education or experience, many development facilitators believe that they already understand a community's reality, even before they've approached them. And, in fact, many of us do have a deep understanding of various cultural contexts or health scenarios that prove invaluable to the quality of our work.

Nevertheless, as we embark upon facilitating community reflection, SAA requires us to focus as much on **what we do not know** as what we already know. We must be curious enough to work with communities to explore fully their complicated social realities, as viewed from their perspectives, not ours. Although the aim of these community reflection exercises is to help communities enhance their understanding of how social factors impact health, we, as CARE staff, must be willing and able to enhance our own understanding as well.

Personal Reflection

What is your intention when you bring together community members at the outset of a project? To affirm what you think you already know? Are the outcomes of your discussion already predetermined? Do you allow the outcomes of early conversations to alter your understanding of the issues you need to address, or how you should address them?

Who: SAA encourages facilitators to seek out diverse social actors and bring them together in conversations about their own health and social realities. This could involve approaching existing community groups or actively seeking out the "invisible" groups whose voices are usually absent from community or political decision-making. Yet identifying these invisible groups is not necessarily a straightforward task. Usually, community leaders do not immediately identify them, and while CARE staff members might have their own assumptions about vulnerability or invisibility, these do not necessarily reflect community realities.

For example, a CARE Uganda project engaged communities in initial reflection exercises to define vulnerable youth, expecting that unmarried pregnant girls would be identified. Yet, as a result of extensive discussions involving diverse actors, the community identified a new, previously unidentified vulnerable group: boda-boda boys, who work border crossings, transporting goods and people with their motorcycles. Considered "bad" by many in the community because they were sexually "dangerous" to young girls, this group was socially excluded and therefore disadvantaged in terms of obtaining education and services. In this way, extensive community reflection helped CARE staff members broaden their own understanding of "vulnerability" and, in turn, help the community to engage with people they had previously considered dangerous.

"The boda-boda cyclists were considered useless in the community. The boys were thought of as defilers, drug abusers and thieves. But now they are recognized in the community. This has taken place after the dialogue and consultative methodology of ProSCAd.

– partner NGO manager, Uganda

Virginia Lamprecht/USAID

What: Your aim is to create understanding of how a community's complex social realities impact its health. This will require you to ask a wide range of questions and never stop asking "why" in order to dig deeply into critical issues.

As health workers, we have generally used the baseline assessment process to ask questions like: What are your maternal mortality rates? What are STD rates among youth? Where do you go to get information about HIV/AIDS? SAA asks that you continue to ask these critical questions, while adding others that will give you and the community a more integrated understanding of the relevant health issues. For instance, typical SAA questions might relate to:

- **Social norms or values:** What do people think is the ideal number of children to have? Do they believe that they have power to determine their ideal number?

- **Daily actions, behaviors and relationships, in relation to an identified health problem:** Who in the family makes decisions about who to marry and the number of children to have and when? Who is involved in decisions on whether a woman can begin using a modern family planning method?

- **Policies, structures, and health systems that impede or enhance health:** Do health policies allow women to seek family planning methods without the consent of a partner or parent? Does religious doctrine discourage the use of modern family planning and why? Do service providers treat unmarried people who are sexually active differently from married people?

Because communities might not have been asked these questions before, particularly not in the context of a health program, they might feel confused, or the conversations might become contentious. Explaining to community members why you are asking these questions is the first step to helping them make the linkages between their lifestyles and their health.

Three Communication Approaches

We have found that facilitating deep, critical community reflection will usually involve three different kinds of communication approaches, all of which are intended to catalyze breakthrough conversations that help communities understand the linkages between social factors and poor health. These three approaches might be used over a series of conversations or, in some cases, during the same session.

- **Exploring:** SAA takes an open-ended, exploratory approach that fully engages communities in analyzing many social factors impacting health. You will need patience, curiosity and creativity to drive the community in this reflection process.

- **Challenging:** Exploration might lead community members toward acknowledging how some of their own values, customs, beliefs or behaviors contribute to poor health. Alternatively, community members might be unwilling to acknowledge the role their social conditions or choices play in perpetuating poor health. In these situations, you will need to ask more provocative questions, or boldly encourage community members to see their reality through a new lens. Your willingness to challenge a community can be the difference between reinforcing social taboos and creating critical new space for reflection. You will need courage and clarity to ensure that your challenging is constructive, rather than destructive, to community morale, and that by challenging community members, you are helping them to move closer to creating sound project interventions.

- **Negotiating:** Members of the community will often have different perspectives on social factors or health issues and how best to address them, particularly when you have diverse participation in dialogue about complex issues. You will likely spend some of your time as a facilitator negotiating opposing or

differing viewpoints in order to arrive at an agreeable outcome. As CARE Malawi staff found, this might involve relying on community mechanisms to resolve community members' own disputes, encouraging the process as necessary.

Evelyn Hockstein/CARE

They (topics of early marriage, HIV/AIDS and teachers abusing pupils) are interesting to me because, practically, they are evident and happening in our community. Most young girls are given to old men for marriage at an early age, and our people say that it is tradition.

– Innovations Project participant, Sierra Leone

Some Issues to Consider

■ *When and how should we engage communities on social issues relating to health?*

This first reflection involves community members identifying the health problem they would like to work together on. By general agreement, the group defines this problem as relevant to everybody's well-being, which is the first step to ensuring community ownership. At later stages of these discussions, community members will begin to focus on social factors impacting that health challenge, some of which may be very sensitive. Through these discussions, community members will eventually identify a shared goal – in Malawi, for example, the goal was to reduce maternal mortality – and agree to methodologies to address the social issues underlying it. Creating this goal and understanding its social linkages ensures that community members have a clear, shared focus and can ultimately experience a sense of accomplishment in addressing their own challenges.

■ *How do you engage the previously unreached?*

CARE staff members should always avoid imposing their own judgments on vulnerability or forcing public acknowledgment of vulnerability, as naming people can create additional stigma. One way to avoid this is through social mapping, in which communities are asked to name groups of people or households that they believe are vulnerable. Handing over responsibility for identifying excluded groups causes community members to reflect on their social realities, thus bringing to the surface their own understandings of vulnerability and its social dimensions, which some outsiders cannot easily observe. Regardless of the approach, CARE staff members need to be creative, sensitive and practical in their approach, ensuring they create a safe, conducive environment for not only identifying vulnerable people, but also analyzing and addressing the source of that vulnerability.

■ *What is the role of leaders in such exercises?*

Leaders play a key practical role in coordinating SAA activities. SAA also asks that they act as proactive stakeholders in community reflection – for

instance, by adjudicating disputes or gaining community support to include the excluded. By taking a public lead role in the reflection, leaders can help to create a safe space for dialogue, thus giving communities "permission" to analyze their social realities deeply.

It was a big challenge to leaders when they went to the field in Bukuku and heard adolescent mothers getting up and giving their testimonies.

– Innovation Project partner, Uganda

■ *How can we manage community expectations?*

Because SAA dialogue usually takes place within the context of donor-funded projects, some of your priorities will have already been set. By narrowing the focus of community dialogue from the outset, CARE staff can be open and honest about the "strings attached" to the program. For instance, you should communicate clearly that your donor is interested in SRH, and so that is what you will focus on. This kind of clarity is critical to maintaining CARE's integrity and building more equitable relationships with community members that are framed by our respective realities. Still, the project's focus need not stop staff from facilitating integrated discussions that go beyond the project's interests, highlighting those issues that CARE can address while fostering the community's willingness and ability to address its remaining social challenges through other support mechanisms.

■ *When do we know we can stop collecting information and begin analyzing it?*

You can stop collecting information when CARE and the community are satisfied that they can effectively begin to address the identified health challenge. A good understanding of the community context will help you to gauge whether broader participation or discussion topics are required, and when it is time to move to the action-planning stage.

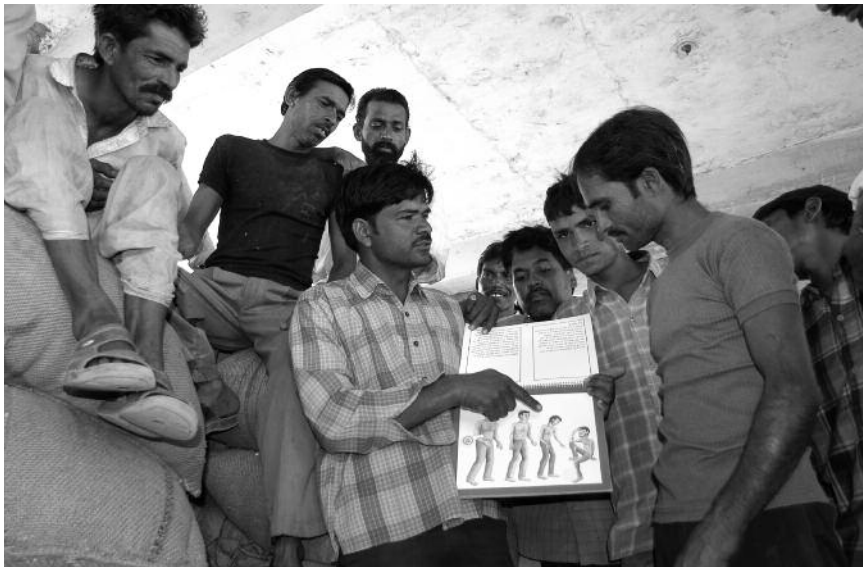
It is also critically important that you have the capacity to analyze, synthesize and utilize whatever information you collect from community reflection. Thus, the scope of your information collection must be framed by practical considerations around your ability to make use of collected data for project implementation. Be careful not to get so caught up in fascinating community dialogue that you lose sight of how to practically apply the information being gathered.

Brendan Bannon/CARE

Reality Check! "I don't have the time, staff or budget to undertake such intensive discussions!"

It is true that the sensitive nature of many socially-related discussions means this step can take longer than traditional assessments. But remember, SAA discussions need only be as intensive as your project requires. CARE staff members must work with communities and other stakeholders to determine an appropriate investment of time, depending upon available resources and demands. Some tips:

- Well-prepared staff and a good understanding of what you require will help you to quickly reach valuable discussions.
- Utilize your most experienced or skilled staff to get the discussions started, allowing more untested staff to observe, follow their lead and take up the discussions as they carry on.
- Do not feel you have to begin challenging a community immediately, or quickly launch into sensitive discussions. Take the time to allow the discussion to build or deepen at a reasonable pace.
- A community that trusts the relevant CARE staff members will engage in this dialogue more openly and honestly. Do not try to push sensitive conversations if you do not feel you have a solid grounding in the community.
- Practice will prove invaluable; you might find that the more you facilitate these dialogues, the more efficient they become.



CARE

Step Three: Plan for Action

SAA can enhance action planning in three key ways:

- **More engaged community members:** CARE's experience is that wide participation in more probing dialogue generally results in community members feeling more fully engaged in CARE's programs and better prepared to lead them. So, you might find that you have a wider range of people interested in involvement with program planning, or anxious to initiate activities. Such interest and momentum can be critical to translating analysis into action.

- **More open dialogue:** Open and widespread community dialogue can often serve to open up new pathways for conversation within a community. Greater openness and willingness to speak can aide your planning processes by keeping discussions exploratory as well as honest and realistic.

- **Greater information:** The depth, breadth and quality of information collected should enhance your planning processes by directing you to the relevant issues. You should be able to focus your attention on planning interventions with a higher likelihood of impact.

How is this SAA step different from action planning in traditional SRH projects?

Discussions about change as well as actions to create change in power structures, gender and other traditional community roles (whether disadvantaged or not) can create political controversy and social conflict. Ethically, program staff members need to engage early with community leaders and members in discussions on what might occur because of project activities, so they can judge for themselves to what extent they are ready to tackle social issues.

Action planning should include discussions to consider potential positive or negative impacts of any planned action or intervention during its initial stages.

Managing Action Planning

With a greater amount of information and more diverse participation, planning could prove more difficult to manage. CARE staff need to maintain efficiency, remembering that their aim is to arrive at well-designed health interventions. At the same time, we must foster community-management capacity. CARE's intention is to enhance community assets wherever possible, so make sure to identify the good planners in the community and how they usually take steps to action.

Conflict can occur at any stage during SAA, due to the potentially sensitive nature of the topics discussed and the diversity of players involved. In fact, it will likely emerge during community reflection and particularly during action planning, when reflecting on social factors shifts to discussing what to do about them. This talk about action can heighten a community's discomfort and fear of change. For instance, while community members might have

We never thought it could ever go this far. The kinds of discussions about deeply felt issues we have had on rights, on women's and men's roles in health and development, and on religion have led to new relationships and discussions with communities.

– CARE staff member, Ethiopia

acknowledged how a cultural practice such as wife inheritance contributes to the spread of HIV/AIDS, they might struggle to determine what to do about that cultural practice, as this kind of deep social change doesn't come easily. At the end of this section, we offer a personal reflection from the director of a CARE Innovations Project in Georgia, who shares her experience managing the conflict wrought by SAA approaches. We also once again deal with the issue of conflict under the next step of implementing actions.

At the beginning it was difficult, even risky, to talk about FGC. Now it's a main discussion point in the villages. Patience and dialogue are key to how CARE staff approached initial distrust from the communities. One Afar man was allegedly so fearful that CARE staff members were coming to prevent him from circumcising his daughters that he pointed a gun at the two field workers and held them hostage inside their car. The CARE staff rolled down the window and talked to the man for an hour. Then they got out of the car and talked for another two to three hours. Finally, the man gave them Afu (a ceremony asking for forgiveness). Now he is one of the project's organizers.

– resident of an Afar community, Ethiopia

Some Issues to Consider

■ *How can we prioritize which social issue to address?*

By opening development doors, SAA produces a great deal of information about social factors fueling poor health. Our experience shows that communities can and should only address one or, at most, two issues at any one time. By gradually taking on issues, communities can gain valuable experience and confidence in implementing projects. Furthermore, prioritization is another critical reflection activity that can stimulate community members' analytical capacity.

Facilitators can help communities to prioritize social issues based on their impact on the identified health problem as well as their willingness and ability to address an issue. For example, communities supported by CARE **Malawi** identified two primary SRH-related issues they wanted to address: social support for vulnerable mothers and sexual exploitation. Through planning, the community decided to deal with support for vulnerable mothers because it was less politically controversial, and therefore progress was more feasible. That decision proved wise. Tackling a less-controversial issue gave the community good project experience, which might enable them to tackle thornier issues in the future. Community leadership can play a critical role in leading the prioritization process to ensure that the issues selected can and will be addressed, given existing resources and the prevailing community climate.

Jaime Stewart/CARE

■ *Who should be involved in action planning?*

The nature of CARE's role will depend on various contextual issues, including community capacity, the personalities involved and the resources available. CARE's role in negotiating and fostering might prove particularly useful at this stage – i.e., negotiating between competing priorities or activities and fostering the ability of community members to lead the planning themselves. CARE can also play a key technical-assistance role by suggesting appropriate methodologies to address identified health challenges. CARE's global experience will no doubt prove invaluable to community members trying to determine how to change deeply held beliefs, customs or behaviors.

The number of community members involved in planning might be smaller than that involved in community reflection. While open community meetings are needed to inform and increase awareness in the larger community, planning usually is the responsibility of a small group of people representing different community voices. In fact, planning will likely only succeed with a core group of strategic stakeholders. Too small a group might not be considered representative; too large a group will likely make the planning cumbersome. CARE staff can help to advise the community on the nature and size of the ideal planning group, based on CARE's knowledge of community dynamics.

CARE staff should advise a planning group to plan small, incremental interventions – action plans are often 3-6 months in duration – so that adjustments can be made as activities are completed and/or as new plans are made to address emerging issues. In **Kenya**, for example, a CARE-supported program began working with communities to discuss the negative health, psychosexual and social consequences of female genital cutting (FGC), and to encourage debate on the issue. As a result, some groups developed action

plans to speak with other community members about the harmful effects of this practice. As communities began to learn about the harmful consequences of FGC, some community members began to state publicly that they did not want to perform FGC on their daughters in the future. In return, these same people felt intense social pressures against them, and some even felt physically threatened. Although never planned, these early adapters decided to band together in a support group they named the "Circle of Friends," and actions were planned (and supported by the project) by this new community group in subsequent action-planning cycles.

Our experience is that community groups become better planners in later cycles of action planning. Early plans may be quite vague and large in scope, while subsequent plans become more focused and realistic, with people held more accountable for achieving planned actions.

Personal Reflection

In practical terms, what is the difference between CARE staff managing a community planning process and facilitating it? What steps should CARE staff take to enable leadership of the planning process among community members, while still ensuring efficiency and quality?

■ *How can we link different levels of actions around a common social issue?* Through professional networks and consultative forums, CARE staff and regional or national counterparts usually have a larger view of program efforts and resources beyond the community level. In this way, staff can link community plans with other programs or activities that could bring in new resources. In the above example from Kenya, the program brought in religious leaders from outside the community to speak with community members about the erroneous association of female circumcision with religious obligation. The program also included a set of activities that were not community-based, including a media campaign focusing on the rights of women and girls to good reproductive health, and an economic development initiative for women. As this example illustrates, although discussions and activities might be intensely focused on community members and issues, it is critical for CARE staff and partners to remain aware of opportunities to address the identified issues through a range of broader interventions.

Virginia Lamprecht/USAID

■ *When should we introduce activities to address social issues relating to health?* Do we first address health-service challenges or the social issues underlying them? In some cases, it may be better to begin program activities by addressing socially related issues before linking up such initiatives with health services. In **Uganda**, for example, CARE focused on the exclusion of boda-boda boys before dealing directly with improving adolescent SRH services. The logic is that some communities can become preoccupied with health-service issues if they are introduced too early, diverting attention from addressing social factors. Other experiences, though, indicate that it might be advantageous to work with health authorities or national health advocacy experts early on in a program, as they can strengthen the technical aspects of a program and actually strengthen the link between social factors and service issues. Ultimately, we need to work closely with communities to manage

expectations and to discuss the consequences of sequencing in order to make decisions on a case-by-case basis.

■ *How can we ensure that planned actions are completed?*

While participation in planning no doubt creates greater buy-in, the follow-through can often be difficult in resource-scarce communities, where material needs limit people's abilities or motivation to commit to project implementation. Nevertheless, CARE has found that the integrity of the SAA approach and community members' investment in it does, in fact, aid follow-up. CARE should encourage community members to integrate evaluation mechanisms into their action plans, in order to generate ongoing data about the status of project implementation. Community feedback sessions are one mechanism for maintaining community momentum, continuing to promote dialogue and reflection, and gathering information to determine whether plans are being implemented as anticipated.

Reality Check! "My donor will not like SAA!"

Because SAA takes an open, exploratory approach to action planning and implementation, some CARE staff members fear their donors might not approve of it. CARE's own experience in negotiating with a donor to implement the Innovations Projects suggests the importance of "win-win" outcomes. We were involved in ongoing dialogue with the donor, which needed to know its needs were being met, as well as ours and those of the communities in which we were working. Donors may be concerned about the amount of time required to do social analysis and the investment in "reflection" (as opposed to "'action"), not to mention the adjustment of project objectives and interventions based on those reflections. You might advocate for SAA by explaining to your donor how it will result in more focused, effective, equitable health projects, and then illustrate this to them throughout project implementation. Yes, some elements of SAA might look unfamiliar to your donor, but through open dialogue, they can see how it is an essential part of meeting goals, rather than a diversion from them.

Conflict Mitigation: A Personal Reflection

by Maia Tavadze
CARE Georgia

CARE Georgia implemented GAHP, a youth reproductive health project, in a conservative, rural district of the Republic of Georgia from 2003 to 2007. We knew from the beginning that family planning (e.g., modern methods of contraception) would be a very controversial topic for the community, especially the religious leaders. Other prominent community leaders (some mayors, teachers and local government officials) were suspicious of any project with a focus on both family planning and youth, since they were afraid that youth would become more sexually active if they had more knowledge of contraceptives. One nurse, who had worked to support a previous family planning project initiated by a different organization, told us that she had been stigmatized by her community for supporting such controversial views.

"We knew from the beginning that family planning would be a very controversial topic for the community, especially the religious leaders."

We started out very carefully and slowly on this topic. We were concerned about negative reactions from community members. These are the steps that we took, and some of the resulting reactions from community members:

1. As the issue of contraception is a taboo subject in communities of the Guria region of Georgia, the project team decided to invest time and effort in making the project strategy flexible and sensitive to community needs. We made a careful study with community stakeholders of the needs of adolescents, and shared the results of the situation analysis publicly. This was a good place for developing areas of common understanding and concern.

2. Before even starting the project, CARE met with the local religious leaders to explain the project and to find common ground on issues

concerning youth, on which both the project and the local religious leaders would agree (e.g., risks to youth development from unplanned pregnancy, HIV and STIs).

3. We introduced the project in each of the target villages by speaking with the mayor of the village first, and later with teachers and doctors, to explain privately the nature of the project. Then, with their permission, we sent out a public announcement to the general population on what the project would be about.

4. The project announcement was skillfully written, avoiding any mention of family-planning issues. We made the assumption, perhaps naively, that it was safe just not to mention the sensitive issues, and that later we could talk more openly about the plans for STI and family-planning education. After making the general public announcements, the local community leaders, NGOs, government officials and mass media became suspicious, because the early announcements were so general. They requested more detailed information on our work. Unfortunately, in one village, a group of angry teachers under the leadership of the local priest and the school headmaster confronted the staff of our partner agencies, who were planning to share information about the youth peer-education plans with youth in the secondary school.

"In retrospect, we realized that avoiding the topics that were sensitive was not useful, as it made people more suspicious."

This incident could have and should have been avoided. In retrospect, we realized that avoiding the topics that were sensitive was not useful, as it made people more suspicious. I think we could have prevented it had we honestly shared the project plans, with regard to family-planning issues.

5. Later, we clarified these plans with local authorities, religious leaders, teachers and other NGO actors engaged in youth programming through public meetings, in which all project activities were discussed. This helped clarify things for everyone.

6. After this incident, we invited a local consultant to help us analyze the social dynamics of various groups in the community, looking at their needs, interests and positions. This helped staff understand causes of potential conflict and helped us plan more effective, proactive steps to keeping conflict to a minimum. We became more aware of the importance of removing the perceived condition of threat, thus minimizing the occurrence or escalation of conflict.

7. We met regularly with a local priest who was more open to ideas related to our project. We found common ground between his goals and our project goals. We shared our project plans with him before rolling out the interventions; he even previewed some of our theater performances. This communication and discussion helped build trust and increased the confidence of community members to participate.

Some lessons that we learned from GAHP:

- The choice of local implementing partners is critical; choose them after undertaking a mapping exercise of potential stakeholders, allies, vulnerable groups and potential adversaries.
- Develop an "entry point" (common ground to start dialogue) for the community in general; it will be useful to focus on the needs and interests of stakeholders (e.g., they want healthy adolescents who don't have unplanned pregnancies) rather than their positions (e.g., "adolescents must know about contraceptives").
- Use techniques to encourage open dialogue on sensitive topics at the community level.
- Find ways to build project staff skills in conflict assessment and management.
- Find ways to monitor levels of tension or potential violence throughout the course of the project.
- Find ways of reinforcing alliances among marginalized groups.
- If recommended by vulnerable groups, find ways of building potential allies among powerful members of the community.

Step Four: Implement Plans

No amount of community dialogue and reflection will be deemed useful unless it leads to action to improve health status – just as it did in Malawi, where dialogue about marginalized women led to the creation of a manual that describes the ideal care and support for pregnant women, new mothers and infants, or in Uganda, where boda-boda boys and unmarried pregnant women received the health information and support they had long needed.

How is this SAA step different from implementation in traditional SRH projects?

It is easier to plan interventions to improve health services or to promote information linked to good health, because these kinds of interventions are more controlled and time-bound. They touch on knowledge and skills development in great part, and are not particularly controversial.

When planning interventions to address social issues, though, it is not always possible to anticipate when and how communities will react. Responses are not always linear or a direct result of project interventions. Sometimes, communities begin to run with an issue before project staff members are ready! Sometimes, segments of the community become angry or feel threatened. Staff members need to be flexible in their support and ready to react when changes begin to occur.

Social-change interventions demand clarity of vision about who has responsibility to manage issues as they arise. This is a shared responsibility with community leaders. Interventions take time and are not one-off activities. They are iterative and cyclical, and project staff need to adjust to this spatial and temporal program reality.

In fact, the changes resulting from SAA approaches might come in forms CARE staff had not anticipated. In certain Ugandan communities, for instance, boda-boda boys and pregnant young women are now seen as both real people and community assets by their fellow community members. These individual and community transformations must not be overlooked, as they can contribute profoundly to creating an enabling environment for the types of sustained health improvements CARE is seeking to catalyze.

CARE has also seen how SAA can spark unexpected community action. The increased level of agency and openness of communication, combined with an overall focus on assets as well as challenges, could motivate communities to start up their own activities to address health or other social challenges. New groups may coalesce and begin unexpected actions, such as lobbying local government officials for funds to improve a local maternity ward and a road, as happened in **Kenya**.

Nevertheless, conflict remains a serious concern as communities begin to delve into their own change processes. As the Georgia experience illustrates, we must take concerns about angry reactions to project activities seriously. Although conflict can sometimes be positive by forcing issues to the surface, we need to take proactive steps to ensure we are not putting anyone at risk

Many people were opposed to stopping kidnapping; they did not consider it negative. Now we have gathered signatures of people opposed to kidnapping. We have invited the few who do not oppose kidnapping to the trainings being done now by the initiative. There has been some eloping in this village during the life of the project, but no forced kidnapping.

– leader of a local NGO partner, Georgia

Ami Vitale/CARE

or making tensions rise unnecessarily. We can also use our position as a respected international NGO to support socially vulnerable groups and leverage important gains for social justice on their behalf.

In order to manage potential conflict throughout a project implementation period, it may be useful to systematically ask ourselves key questions:

1. Do we have a good understanding of the power dynamics among the various groups in the community, and which groups might be allied with whom, and why? If not, how can we learn what we need to know?

2. Do we have project partners that are considered to be in alliance with vulnerable groups, or powerful groups? What might be the impact of those perceived alliances?

3. What would be the pros and cons of building alliances with powerful groups or individuals in the community?

4. How can we build opportunities to encourage positive dialogue and/or strengthen local systems, structures or processes that are used to resolve conflicts peacefully?

In some cases, CARE staff members may also become targets of community anger. Project managers need to be aware of potential outcomes through regular, open communication with staff and stakeholders, and the safety of all involved must be prioritized over any perceived progress toward achieving project aims.

Some Issues to Consider

■ *What are initial activities that projects can undertake to support social-change efforts?*

Creating public spaces for dialogue is one key initial activity that helps communities take practical steps to address socially related health challenges. Communities should not see the implementation phase as signaling the end of dialogue. By creating neutral venues for discussion between more powerful and less powerful people, CARE can help to continue to promote breakthrough dialogue and action to address social factors impacting health. These dialogues can also encourage leaders to fulfill their roles in addressing social issues that might not have been prioritized in the past.

Communities will likely become more emboldened as they succeed in implementing early activities. In fact, successful implementation of action plans often makes groups feel more empowered and confident to address more difficult social challenges. Through regular planning-action-reflection cycles, they can build upon achievements in prior cycles to expand their role in addressing health issues.

■ *Are there times when is it not appropriate to tackle social issues?*

We have stated throughout this guide that SAA approaches can easily be integrated into traditional health programs in order to enhance their effect. In some instances, however, other activities might be more critical – for example, during an emergency or in immediate post-conflict settings. In other cases, donor support is available for too short a time to adequately engage and build the capacity of communities to address social issues. Or sometimes, the political environment is such that social-change work would create more harm than good. In such cases, it would be more responsible for CARE staff to limit SAA activities in order to ensure that communities are not left without external-facilitation support in the middle of a social-change process. CARE staff must work with partners and stakeholders to determine whether SAA interventions would be appropriate and beneficial in a given context, and, above all, to ensure that the principle of "do no harm" is followed.

We were having trouble mobilizing men and getting them to stop exploiting girls, but the community dialogue meetings have been changing their behavior.

– partner NGO member, Uganda

Virginia Lamprecht/USAID

Step Five: Evaluate

Implementing programs that lead to social change means we must move from measuring standard and easily quantifiable changes in health-service uptake and knowledge gains to measuring social and structural changes. This can prove challenging, because both the process and outcomes can be unpredictable, combining subtle shifts and large-scale social changes. In order to understand and document both the process and outcomes of social change, we must adapt key aspects of our monitoring and evaluation approach accordingly.

How is this SAA step different from evaluation in traditional SRH projects?

While typical SRH programs use standardized and quantifiable indicators to evaluate impact, such as contraceptive prevalence rates, there are not yet commonly accepted indicators for evaluating outcomes of social processes and their pathways to improved SRH outcomes. Likewise, ways to measure health equity have long existed at the national level, but are only now beginning to be developed and tested with smaller populations and at the community level. There remains a significant need to develop a knowledge and evidence base to guide measurement of programs focusing on social change.

The current state-of-the-art methods of evaluating social change depend heavily on qualitative data and assessing changes using social-science **measures**, like indicators that gauge community capacity or perceptions of leadership and inclusiveness around SRH-related issues.

Evaluation **methods** at a project or community level are also drawn from the social sciences, including social mapping, Most Significant Change discussions and observed changes in social patterns, communications and networks.

First, observation and regular community consultation become critical to charting progress and noting subtle changes in health and other social factors. Second, you will need to find strategic ways of integrating reflection into your project implementation approaches, to ensure that measuring and questioning observed change becomes an integral part of your project's work. Third, new evaluation methods that are appropriate for social-change programs will need to be used to capture the range of changes that can occur, both expected and unexpected. Now let us look at each of these in more detail.

Observation is a monitoring tool that should be integrated throughout the project cycle; it includes active data collection, analysis and assessment of changes. It will require us to ask questions like:

- What do we know (and not know) about what is happening at the field level?
- What changes are happening at the project site? Why?
- Who is actually benefiting, and who is not?
- Are the project activities really achieving their intended effect? Where is the power now? What are the unintended consequences?
- Why are we implementing projects this way?
- Are we contributing enough to the creation of positive change in people's lives? How could we do more?

Because observation is an ongoing activity, CARE staff members should institutionalize mechanisms for capturing and utilizing observations to ensure they do not get missed, and that they are effectively utilized to improve the quality and impact of project interventions.

Reflection is a critical companion to observation, allowing us to analyze what we find through observation. Our experience has shown that making time for staff and communities to step back and reflect is critical to improving a project's effectiveness. We are then learning by inquiry, often referred to as "reflective learning."[1] (See page 101 for a description of Reflective Practice.) Reflective learning is an ongoing process in which anyone in a particular situation – in this case, CARE staff members implementing a health project – take time to examine their experiences, to reflect on them, to consider how things might be different, to contemplate these possibilities, and to try out what seems to be the best option. But this is not the end; trying that option becomes another experience in itself – to study, reflect upon and act on again.

Staff should build periodic reflection times into program cycles – for example, every 3-6 months. At this point, key stakeholders should meet to analyze results, share observations, assess original hypotheses, discuss the need for more social analyses and determine the need to adjust project activities to improve their effectiveness.

Finally, you must utilize **new evaluation methods** that help systematize collection of a new range of social-change outcomes, in addition to indicators for knowledge, attitudes and practices. For example, the Most Significant Change process has proven particularly useful in identifying a range of social changes. (See page 105 for a description of Most Significant Change.) In **Peru**, CARE worked with civil society organizations to raise awareness of the health rights of all citizens. At about the midpoint of the project, staff used the Most Significant Change method to explore changes in the project site. Staff asked women in the target community, "What is the most significant change you have seen in the last year?" Women said they felt they were **treated with more respect by staff** and thus were not intimidated to go to the clinic. In this way, Most Significant Change helped CARE to identify a subtle shift in the women's sense of position within their society, which impacts directly on their ability to access health services.

Some Issues to Consider

■ *How do we ensure the full range of SAA outcomes are captured?*

Evaluating projects that have utilized SAA approaches requires us to maintain a dual focus on social and structural changes as well as improvements in people's health. What makes this challenging is that this social change can come in a variety of forms, and at a number of different levels. Thus, CARE staff members need to have a firm grasp of the range of possible social changes occurring. While looking for evidence of change at the community level, it is possible to see changes at both the individual and group level. Some specific social changes might include:

1. **Less discriminatory, stigmatizing or violent behavior and attitudes** – men contributing equally to household chores or parenting, for example, or employers hiring without regard to HIV status or sexual orientation.

2. **Improvement in personal attitudes toward self-worth and value**, with changes in behavior that show a willingness to stand up for one's own rights.

3. **Greater and more equitable civic participation** by community members, especially groups who experience stigma or discrimination; this includes equal involvement of marginalized groups in community leadership, decision making, and governance systems and processes.

The barriers between castes have broken. Now we are friends. Earlier, we used to discriminate a lot. As we started coming together, all hesitations have washed out. All humans are alike; their blood is the same. So why should we discriminate against others?

- young woman, India

Phil Borges/CARE

4. **Improvement in equitable treatment by state services** – for example, doctors and nurses respecting their clients' wishes and traditions and giving everyone equal access to services, including stigmatized groups; police, lawyers and judges treating survivors of violence with respect; mayors, local government officials and chiefs equitably enforcing state policies and laws, treating people accused of crimes equitably and allocating local funds for services equitably.

5. **More equitable treatment for community members by individuals who represent state services:** for example, doctors and nurses respecting clients regardless of ethnicity; police, lawyers and judges treating survivors of violence with respect; or mayors, local government officials and chiefs equitably enforcing state policies and laws.

6. Enacting, revising and implementing **structures, policies and laws** that represent an equitable distribution of justice: for example, laws to equally protect men and women as well as people of all races, castes, ethnic status, nationalities, economic classes, or sexual and gender identities.

7. **Increased social cohesion** (sense of belonging, morale, goal consensus, trust and reciprocity), evidenced by effective formal and informal social networks, including inter-organizational partnerships.

8. **Changing social norms** (unwritten laws that people enact through their interactions with others) so that everyone has equal respect, dignity, chance, choice or access: for example, a reduction in discriminatory attitudes or behavior (such as norms related to dowry, child marriage, domestic violence, sex or birth outside of marriage, or assumptions of heterosexuality) that is so widespread that it is considered normal. At a minimum, this might also include increased public dialogue about these public assumptions or discriminatory attitudes, or evidence of activism by groups, networks or coalitions to change public attitudes and behaviors.

Personal Reflection

What is the best way of balancing the community's need to know with our need to report to donors? Do we have positive experience in simultaneously meeting community and donor needs for information? One group of HIV-positive women came up with their own evaluation criteria (see their evaluation document, Positive Women Monitoring Change, at www.icw.org/files/monitoringchangetool-designed.doc.

■ *How can we make the best use of qualitative data?*

Because SAA produces more qualitative information than quantitative, there is a chance you might feel overwhelmed by the amount of information you have collected or unsure of exactly how to make sense of it. In order to ensure that you are well-positioned to utilize evaluation data for the purposes of project improvements, there are three key logistical issues you should consider when preparing for your evaluation:

- **Time commitment:** Be clear about how much time you have available for information collection, analysis and use. Be careful not to get so caught up in information collection and analysis that you lose sight of how to use it to improve project quality and outcomes.
- **Information gathering:** Because social change is broad, staff and stakeholders should have a clear sense of the type and quantity of information needed. The categories listed above should help you organize your thinking in this regard.
- **Information analysis:** Whether through paid staff or consultants, make sure your project has the ability to systematically organize, analyze and utilize the data collected.

[1] More information about CARE's experiences in reflective practice can be found in "Learning By Inquiry," which can be found at www.care.org/reprohealth

Section Three: Social Analysis & Action Case Studies

As we stated in the Introduction, SAA has evolved as a result of CARE staff continually exploring and experimenting with their partners. The following four case studies will give you a flavor of that real-life experience, shedding light on various aspects of SAA implementation.

- The **Sierra Leone** experience illustrates how SAA can help a project to further narrow its focus and enhance its impact. Staff and partners of the SAY project undertook rigorous, often challenging social analysis in order to better understand deep socio-cultural factors affecting adolescent SRH in their focus villages. This case study can help you to understand how SAA might enhance your project's overall quality.

- The **Malawi** case study further explores the concept of challenging a community to acknowledge and address tricky socio-cultural issues. Staff members of the MINERSH project found they had to provoke frank, exploratory dialogue in order to help community members to uncover social factors affecting maternal health. If you are curious about the difficulties and benefits associated with the challenge process, this case study will interest you.

- The ISOFI case study from **India** is a perfect example of how familiar participatory tools can be adapted to enable revealing discussions about sexual realities. ISOFI staff members modified the body mapping tool to encourage truck drivers to discuss the emotional, physical and psychological aspects of sex. The results of the exercise were surprising, revealing a sexual subculture previously unknown to ISOFI staff. Reading this case study might inspire you to adapt some of your own tools for use in SAA.

- The **Georgia** case study presents the "forum theater" methodology as one means of enabling community dialogue. We have already read about the resistance the GAHP project faced when it initiated adolescent SRH work. In light of that, the gains made in catalyzing community discussion and behavior change are particularly significant. This case study not only explores a valuable methodology, it also shows how CARE staff can turn around a contentious situation in pursuit of profound social change.

Read these case studies, learn from them and let them inspire you to experiment, knowing that you are part of a growing community of people utilizing SAA approaches to help better understand and address clients' needs.

Jaime Stewart/CARE

How do we ensure that our projects respond to the real health needs of young people? Knowing the relatively powerless role that youth play in society, how do we engage parents, family members and youth themselves in understanding and addressing the multitude of factors that influence their sexual decisionmaking and health? The Sexuality and Youth (SAY) project in northern Sierra Leone's Koinadugu district attempted to fully explore and embrace the complex social and cultural realities facing youth in the region. Recognizing the importance of addressing adolescent SRH issues in the context of the family as well as the community as a whole, CARE Sierra Leone and its public-sector partners sought to improve SRH decision-making among adolescents through access to information and increased dialogue at the societal level. SAA has been an integral component of this project, helping the SAY team to dig deeper into the social and cultural realities affecting youth, and to tailor the project to address these realities. In the process, both staff and community members found themselves publicly confronting issues they had never discussed before.

Sierra Leone: Tailoring SRH Projects to Meet Adolescent Needs

Background

Extreme poverty, cultural practices and the breakdown of social structures during and after war have left many youth in Sierra Leone lacking livelihood options as well as information on SRH services. These adolescents run a high risk of making, or being forced into, negative reproductive health choices, which can affect their entire lives and the lives of their families. Such choices, made for adolescents or by them, lead to high rates of unplanned pregnancy, early marriage, adolescent maternal mortality, HIV/AIDS and STIs, and coercive and forced sex. Another related problem, though not explicitly an SRH-related choice, is the very high rate of school dropout for both girls and boys in their adolescent years, which is often accompanied by early marriage and/or early pregnancy.

Sissy Aminata is the name of a participatory package designed to involve youth in discussion and problem solving on issues related to their reproductive health. The character of Sissy Aminata is a respectable older sister one seeks out for advice. In school-, community- and radio-based sessions, groups of adolescents ages 12-19 read or listen to recorded tapes of letters from other young people to Sissy Aminata, or have discussions about the letters on the radio with Sissy Aminata "herself." These letters include real adolescents' concerns about their sexual and reproductive health. Through self-guided discussion, the adolescents then consider the subject of the letter, including their ideas for how to overcome the problem or concern described. The group listens to Sissy Aminata's response, giving "her" advice for the adolescent and then further discusses how the members perceive that advice and how they might put the advice into action in their own lives.

Given that adolescents often cannot fully control their sexual and reproductive lives, the project also envisioned activities to raise community dialogue around SRH issues. The purpose of these activities was to improve the supportive environment around adolescents, so they can make positive SRH choices.

Understanding Adolescent SRH in Sierra Leone

After the initial design of the project, CARE Sierra Leone undertook a social analysis to refine the project design and to inform future social-analysis efforts. Recognizing the need to improve the supportive environment around adolescent decision-making, the research team was particularly interested in a clearer understanding of the environment that influences, shapes and sometimes determines adolescent sexual and reproductive behaviors.

The social analysis was carried out in two chiefdoms of the Koinadugu district, each representing one of the dominant ethnic groups. The research team was made up of staff members from SAY as well as a number of other projects being implemented in the district. Their investigation included a wide array of people who were, or potentially were, part of adolescents' supportive environment, such as community elders, parents, teachers, chiefs, female leaders (mammy queens), religious leaders and adolescents themselves. Through focus-group discussions, every group was asked to respond to a set of core questions around the key SRH issues facing adolescents. Creative exercises, such as a values exercise and a lifeline exercise, were added to help the research team to explore with the participants the potential cultural values that influence adolescent SRH, and to understand community perceptions of the life of a typical woman from each ethnic group. This enabled the researchers to see if there were differences across groups as well as generations.

CARE Sierra Leone/CARE

Meeting the Needs of Adolescents in Koinadugu

The act of carrying out the social analysis was, in a sense, almost as important as the findings themselves. This is not to say that the findings weren't significant! Rather, the staff and projects involved in SAA were in some ways changed themselves, not only the planned implementation of the SAY project.

The most direct change to the project was in the form of **new themes** added to the Sissy Aminata package. Sissy Aminata was originally adapted for an urban audience in Freetown, Sierra Leone's capital city, but the rural Koinadugu district is far from Freetown. Findings from the social analysis clearly pointed to the need for more focus on early marriage, economic issues such as money or goods in exchange for sex, fertility awareness and pregnancy prevention, and deferring sex.

Carrying out the social analysis also cemented the need for CARE to address the supportive environment around adolescents as well as adolescent decision-making itself. Prior to the social analysis, there was a particular emphasis put on the immediate families of adolescents. And while the

importance of families is clear, the social analysis led project staff to understand that adolescents approach problems not only within the family but with the larger community as well. This includes community members such as in-laws, traditional leaders, elders in the community and religious leaders.

The findings from the social analysis were presented to the communities in the form of a role play, to both validate the findings and begin a community-led reflection process on potential activities, outside of Sissy Aminata, that would support positive, adolescent SRH decision-making and improve self-efficacy. This eventually led to the adoption of a methodology called Diagnostic Role Plays, very similar to the forum theater approach that is discussed later in the Georgia case study.

The ripple effect of the social analysis on other projects was impressive. Several positive changes were brought about by motivated members of the social analysis team:

- **Community Decision-Making Processes:** Carrying out the social analysis led staff to better understand these processes and to adjust programming accordingly. For example, after hearing that women find it difficult to take action around their children's SRH because they are not consulted, the Child Survival Project modified its facilitation of pregnant women's clubs to include husbands and mothers-in-law.

- **Responding to Economic Needs:** After hearing about the high rate of sexual contact that is practiced by adolescents out of economic need, CARE's livelihoods sector added savings-and-loan activities to the mix of activities already offered in Koinadugu communities.

- **Highlighting Girls Education:** After not one group using the lifeline tool mentioned sending girls to school as an important issue, the assistant project manager of the Child Survival Project successfully lobbied for that project to take a child-rights perspective and include girls' education in discussions with community health clubs, with an emphasis on parents and communities as duty bearers.

Valenda Campbell/CARE

Challenges

As the research team explored the supportive environment and factors affecting adolescent SRH, their social analysis raised almost as many questions as it answered. For example, through using the lifeline tool, both men and women acknowledged that women were mistreated by family and society, but underlying reasons for this were not revealed. Similarly, a downward shift in age at initiation (including female genital cutting) was uncovered, but the analysis wasn't able to shed light on why. Given the many questions raised by the social analysis, the SAY team almost immediately decided to continue the process of learning through planned research throughout the life of the project.

Another challenge has been addressing some of the more **culturally sensitive** adolescent SRH issues. On the one hand, the trust and dedication that the field agents have engendered in the Sissy Aminata clubs has been one of the project's key strengths. But on the other hand, staff members are drawn from populations that are the same as or similar to those they are serving, and thus might be reluctant to highlight or even discuss culturally sensitive issues. For example, secret societies are extremely powerful and highly politicized bodies in Sierra Leone; members initiate adolescents, provide SRH teaching, and perform female and male circumcision/cutting. SAY project staff members were initially reluctant to address the role of such embedded cultural practices on SRH outcomes. CARE has since decided to invest in learning more about them and is about to embark on a separate social analysis as a first step to working with communities to mitigate the negative impact of female genital cutting.

Valenda Campbell/CARE

Lessons Learned

Through carrying out the social analysis and following up on learnings from it, CARE Sierra Leone has been both challenged and enriched. Staff members who were involved are quick to say how meaningful the process was for them, even those from Koinadugu. But they are equally quick to recount how difficult the process was, especially the effort to analyze the varied responses heard in focus-group discussions and the other exercises they carried out. In a recent discussion on how the social analysis changed CARE programming, it was clear that many changes were brought about, with perhaps the most important being the willingness to continue to work to gain a deeper and more complex understanding of underlying causes of the problems that CARE aims to address.

What happens when an international development organization challenges the norms and beliefs of the very communities it has set out to help? Do you risk alienating them? Or does your intervention help these communities to finally address the root causes of poor health among its members? The MINESRH (Models for Inclusive and Equitable Sexual and Reproductive Health Services) project in Malawi grappled with those questions as it sought to challenge community norms regarding equitable access to maternal and newborn health (MNH) services. In trying to address the root causes of poor MNH in three areas of the Ntchisi district, MINERSH decided to go beyond the standard package of SRH service interventions in order to challenge patriarchal norms and beliefs that continually reinforce the cycle of poor health among some women. It was a risky decision and one that threatened to put the project at odds with people who needed its help. But by building a sound foundation of mutual trust, open dialogue and equitable relationships, MINESRH was able to help these communities to acknowledge the role they played in continuing the cycle of poor health, and what they could do to stop it.

Malawi: Challenging Community Realities

Background

Accessing healthcare services is difficult in Ntchisi district, a rural area 2.5 hours from Malawi's capital, Lilongwe. Medical assistants and nurses provide services at only three local health centers and one district hospital, and few local or international NGOs work there to fill the gaps.

There is another factor that impedes access to healthcare in Ntchisi, a factor you wouldn't see if you visited, but one that exerts a powerful force on community members, particularly women. The Chewa people who populate the district are a traditional patriarchal society, in which men make reproductive health decisions and sexuality is not usually discussed between men and women. The result is a **lack of open, informed dialogue** about pregnant women's health and the frequent failure of women to be able to access the kind of support they need to maintain a healthful pregnancy. This combination of lack of services and repressive norms means many pregnant women are often left suffering in silence, inside their own homes, out of reach of the services they so desperately require.

MINESRH set out to help pregnant women in three communities in the Ntchisi district access the MNH services they require. One aspect of the intervention was relatively straightforward for a development organization like CARE: determining and improving access to a basic package of healthcare services. But another aspect of MINERSH's work sought to go deeper, to plunge further into the patriarchal beliefs that everyone in the community knew kept women from receiving necessary support. Why? Because staff members knew that if MINERSH didn't challenge those beliefs, even the best MNH services could go unused by the very women who needed them the most.

Facilitation Versus Challenging

Terms like "facilitating change" have become commonplace across development organizations like CARE. So how does facilitating communities' change differ from challenging them? The simple answer is that it is not that different. Both approaches attempt to catalyze conversations among community members about how their behaviors and beliefs can sometimes entrench poverty and poor health.

By using terms like "challenge," MINESRH and similar projects acknowledge that sometimes these conversations are difficult, that they involve **provoking communities** to help them to realize how their behaviors contribute to their own poverty. This is not always an easy or pleasant encounter; in fact, it can involve a clash of cultures, beliefs and power. CARE increasingly believes that this clash is necessary, not only to help people realize how they are part of a problem but also to empower them to provide solutions. For MINESRH, challenging communities involved working with them to slowly uncover attitudes and behaviors that were leading to inequalities in support and care that women receive during pregnancy and childbirth. The team probed those differences and confronted people to question their beliefs and take action where they saw the need for change.

Maggie Steber/CARE

By increasing debate about communities' responsibility to provide support for pregnant women, MINESRH believed that community members would accept that all pregnant women had a right to healthcare and would subsequently seek to enforce that right. In other words, MINESRH did not challenge community norms simply in order to promote more progressive beliefs. The project believed that challenging communities would ultimately increase social support for pregnant women, which would, in turn, improve health outcomes. In this way, challenging community beliefs was the necessary first step in empowering them to take control of health services.

Creating the Trust to Challenge

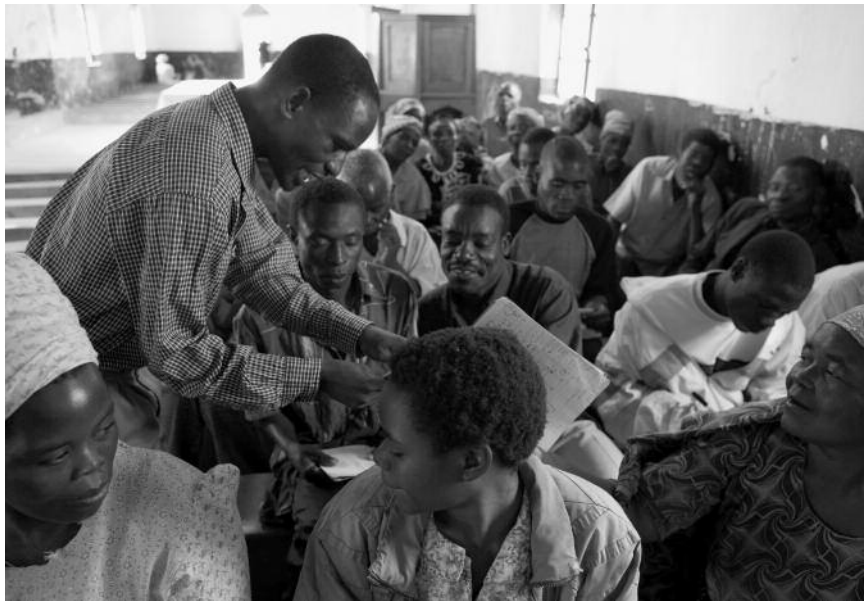
MINESRH did not underestimate what would be required to challenge its community partners in a way that would not introduce conflict or fundamentally alienate CARE staff from community members. Indeed, MINESRH staff members knew this experiment could go terribly wrong if they did not have the necessary skills, if trust was not built with the communities, or if equal, open relationships were not created with community partners. So, the project made an investment – of time, skills and funds, in itself as well as in its target communities – which it believed would pay off in more sustainable SAA outcomes.

The Foundation: Staff Self-Reflection

Project leadership recognized that behavior change might have to occur within MINESRH staff before the project could seek to bring about similar change among community members. So a project advisor, already familiar with project staff members, initiated discussions that encouraged them to think critically and question their own values and attitudes. These intensive discussions, which took place over the course of two weeks, quickly moved into personal issues. The conversations linked the team's SRH experiences to the project's goals, looked at how staff attitudes marginalized certain people and explored staff comfort level in discussing sexuality. By experiencing behavior change firsthand, MINESRH staff members understood better the difficulties the communities would face as they struggled to change, both individually and collectively.

Introducing the Project

Next, MINESRH staff met with community leaders, including traditional authorities, health volunteers and religious leaders, to present the project.



Brendan Bannon/CARE

There were several key differences in MINESRH's approach to these early discussions. First, the specific priorities and strategies for the project were not predetermined. MINESRH staff used these conversations to work with community members to develop a short list of potential interventions based on their needs, the project's resources and its overarching SRH focus. Another key difference was that while project staff consulted with Ministry of Health (MOH) partners in finalizing the intervention focus and strategies, the MOH was not given its traditional dominant role in determining project priorities.

MINESRH staff took advantage of these early conversations to begin to explore why some women in the community received more reproductive health support than others. Through this process, staff members began to see themselves as facilitators, actively listening to and exploring community concerns as well as probing for causes and explanations for their choices. As a result, the community ultimately decided to focus on maternal and newborn health.

Community Mapping

With the MNH focus determined, the project team began helping community members draw maps identifying MNH services and the people who influenced MNH-related issues in the community. Among those identified as providing support for pregnant women and newborns were village headmen (i.e., chiefs) and their advisors, religious leaders and counselors, church group members, traditional birth attendants, women's group (Siwa) leaders, teachers, parent-teacher association (PTA) members, health workers and growth-monitoring volunteers. The community selected these people for participation in further exploratory discussions about MNH services.

Over the next four months, staff and community members, including those identified during the mapping exercise, met about eight times in each catchment area. During these discussions, the team asked questions about who gets support when they are pregnant and who does not, and then probed the attitudes, beliefs and behaviors that served as the foundation for this

difference. In between discussions, team members analyzed what they were learning, including information on social and cultural attitudes toward pregnancy and childbirth, care-seeking practices, barriers to accessing services, identification of differences between those with positive and those with negative outcomes to pregnancy, and ideas of what could be done to address the problem. These findings were relayed back to community members for verification and further discussion, probing and challenging. This often led to the reconsideration of their assumptions and, at times, development of actions for change.

A critical part of the success of this phase were the **attitudes and behaviors** of MINESRH staff members. They learned to approach these discussions in a way that indicated they truly wanted to hear people's concerns and opinions. By probing and exploring as equals, with the attitude that "we" are all learning together and no one is right or wrong, staff began to hear new and different explanations for why some women receive more support than others. In this way, the project's interventions weren't a case of "us" challenging "them," but rather everyone being challenged together.

Valenda Campbell/CARE

Core Groups: Structured Action

These exploratory discussions grew as word about the project spread and people's desire to voice their opinions increased. MINESRH had to find another way to manage them, and thus established three core groups (one per catchment area) of community members to address MNH issues. They called themselves the Amkhalabakati groups, which means "in between" in Chichewa, emphasizing their role as links between MINESRH and their communities.

Core group members included those that had participated in the exploratory discussions as well as influential individuals identified during the mapping exercises. Village headmen became active and responsible members, personally engaged in issues that had traditionally been "women's issues." Other members were linked as representatives from their different village-level groups or organizations in order to eventually facilitate their efforts to mobilize support.

From the outset, the members owned the core groups, developing their own terms of reference and actively enforcing those expectations. Project staff strategically assigned tasks for the core groups to work on between staff visits in order to cultivate their independence. As a result of working together and challenging their social norms, these groups began to accept a level of responsibility for providing social support and equity for pregnant women in their communities.

Core group members then worked with a health center and MOH staff to develop a "minimum package of information and behaviors" for improved MNH, setting a mutually agreed-upon standard for the information and care that all pregnant women should receive. This standard would be consistent with MOH guidelines as well as international policies and standards, including those regarding community-level actions such as birth planning, recognition of danger signs and mobilization of transport options.

With this package, the core groups could work directly and independently on MNH activities. The core groups believed the content of the minimum package was essentially theirs, and thus felt considerable motivation to use it in their communities to improve MNH outcomes.

Challenges

As expected, this intensive, truly community-driven process challenged MINESRH project staff in a variety of ways:

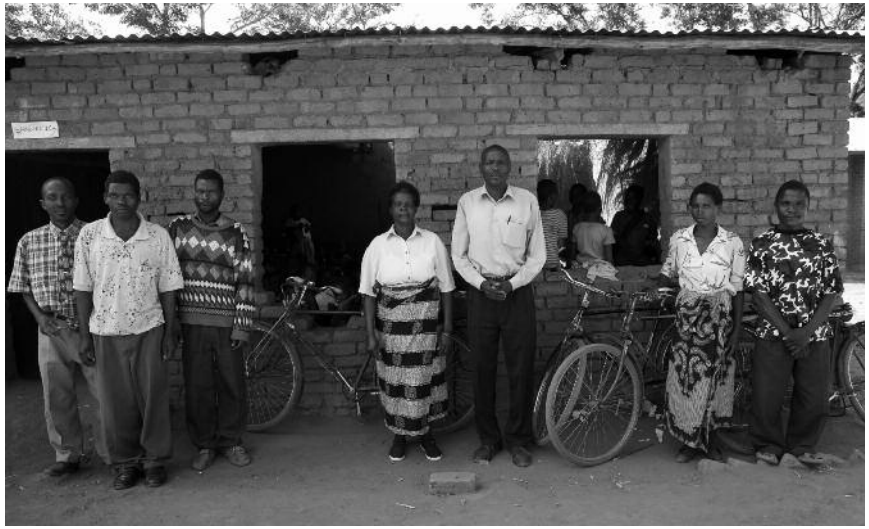
- Perhaps the most obvious challenge was the **commitment of time and effort** this process required. Two full-time MINESRH staff worked with the three health-center catchment areas over approximately 3-4 months to reach the point at which communities were developing their MNH interventions. It remains to be seen whether the process can be streamlined for application in less intensive, more traditional CARE projects in health and/or other sectors.

- Soon after MINESRH staff began consulting with communities, community members started requesting **allowances** for participating in the discussions, like they had received under previous projects. In response, the project team scheduled a meeting with community members to discuss expectations (on both sides) and let them decide if they wanted to participate or not. Once community members made the decision to continue, they began to take more responsibility, and the issues of allowances has not been raised since.

- Another challenge lay in the **representation of socially excluded women** in the core groups. Because the groups had decided not to specifically identify excluded women, based on the stigma that would be attached to the label, the groups were not able to ensure representation by pregnant or less-supported women. As the groups become stronger, they may be able to find a way of including more vulnerable women and girls in a positive, supportive way that emphasizes the importance of their voice and engagement in the process.

Lessons Learned

MINESRH sought to reinvent the relationship between staff and community members, making it more equal and open, as a starting point for SAA. MINERSH staff members acknowledged they had to deal with their own attitudes about sexuality, marriage and motherhood in order to effectively challenge those of the community. This recognition that they, too, might need to change helped to not only increase the effectiveness of their facilitation but also to create a more equitable relationship with communities. Indeed, communities felt CARE came to them as an **equal partner**, that the project listened to what they had to say, and that it took their views into consideration. In contrast, they indicated that when others come into their community telling them what to do, they are polite and listen to what is said, but they don't necessarily do what is asked. Furthermore, because this was such an exploratory, experimental process, staff felt they had "freedom to fail," which allowed them to turn the process over to the communities, resulting in an increased sense of community ownership.



Brendan Bannon/CARE

Taking traditional participatory tools and using them to explore issues once considered taboo: that's what CARE's SRH programs are trying to do today as a way of helping communities and beneficiaries dig deep into the underlying causes of their own poor health. Participation is hardly a novel concept, but deep and often painful exploration is an area where many development organizations have feared to tread. In the ISOFI project in India, CARE used a PLA tool called body mapping to work with men to explore their sexual knowledge as well as the emotions and attitudes associated with sex and sexuality. In the process, CARE staff opened a door and entered a world kept locked away from the mainstream. By opening this door, CARE India staff members were able to move beyond a narrowly defined public health model of HIV prevention among truckers in order to address their real lives and concerns.

India: Adapting Participatory Tools to Discover Social Realities

Background

In 22 large cities in four northern Indian states, the ISOFI project worked to enable men and women to better protect themselves from STIs and HIV by minimizing their risk and vulnerability. The project used a familiar set of interventions, including behavior-change communications using peer educators and mass media; establishing condom outlets; and training service providers. The project paid particular attention to reaching vulnerable groups, including sex workers and their clients, migrants and men working in the long-distance trucking industry – approximately 40 truckers (drivers and "conductors," who are drivers' helpers) who were "transiting" through a municipal truck park in the city of Lucknow. Staff assumed at the outset of the project that this would involve working with truckers to discuss commercial sex workers.

CARE staff had to find ways to initiate revealing, often taboo conversations with the truckers, men who were not accustomed to discussing sex and sexuality. The drivers tended to be in their thirties, educated and often married, while conductors were usually younger men, in their early twenties, who signed up with truckers with the hope of breaking into the trade. Since there was a strict hierarchy between these two groups, separate spaces had to be created in order to optimize comfort and confidentiality. Getting into their personal lives, let alone the interactions between them, was not going to be easy.

Body Mapping

ISOFI used a modified version of the participatory tool of body mapping, one that not only encouraged the truckers to discuss their sexual knowledge, but also their sexual realities. In this version, a volunteer agreed to have an

outline of his body traced onto a large sheet of paper. Participants in each group then drew and labeled different body parts onto the outline, as with traditional body mapping. However, after discussing some anatomy and physiology, group members went on to mark places on the body that gave them **pain, pleasure, power and shame**. Probing more deeply, the group then discussed when, why and in what situations people feel power (or pleasure, pain and shame). Other discussions included why there are different cultural attitudes and opinions attached to body parts and how this impacts how we feel about them, why the same body part can give us power as well as shame, and what is the origin of the feeling of shame itself.

Sarah Kambou/ICRW

Male Sexual Pleasure and Power

Through these discussions, drivers and conductors debated the pathways to sexual pleasure. Some believed pleasure originates with the eyes – through sight and visual stimulation – and then travels to the heart and, eventually, the mind. Others contended that pleasure emanates from the heart – through love and emotional attachment – and is amplified throughout the body upon reaching the brain. The majority identified the penis as the principle source of pleasure, and essential to male sexuality. "The real pleasure lies within the penis," one participant said. "This is the transformative power." The drivers described the penis not only as an instrument of pleasure, but also as a source of power. One man spoke for all of the participants when he said, "If a man cannot satisfy his woman, he feels like dying; there is no point in living."

As the conversations carried on, they grew more intimate and emotional. The truckers spoke of their loneliness on the road and the need to release sexual heat in order to maintain strength and health. Participants alluded to various options for roadside commercial sex, but they also acknowledged the practice of "**cab sex**." As the junior partner in the truck cab, conductors may be

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approached, pressured or forcibly coerced by drivers for sex. Given social hierarchies, financial insecurity and, ultimately, unequal power relations, conductors feel they often have no option but to engage in sexual relations when solicited. Furthermore, according to the participatory learning and action (PLA) participants, most truckers involved in male-to-male sexual relationships while on the road are also involved with female sexual partners, including wives, sex workers and girlfriends. As the body-mapping exercises unfolded, ISOFI staff came to realize that cab sex is neither rare, hidden nor shameful within the trucker community.

What Happened as a Result?

For many project staff members, the body-mapping exercise revealed for the first time that cab sex was not uncommon and that there were men among their target population who enjoyed or sought out male-to-male sex. Therefore, the staff members' own presumptions about heterosexuality and homosexuality were challenged. As one staff member noted, "I had an impression that men who have sex with men are not good ... Now we say that we have no right to say anything, or be judgmental about it. Our thinking has changed." Of course, the staff also realized that, as with heterosexual sex, many of the conductors felt coerced into sex with their drivers. Thus, in seeking to reduce vulnerability to HIV and STIs, the project had to find ways to address hierarchy among these male coworkers as well as male power relations, subjects that had not figured into the project's initial design.

With this information, the ISOFI staff could then design interventions that spoke to the drivers' sexual realities. As a first step to applying this deeper understanding, teams integrated messaging designed for men who have sex with men (MSM) into HIV/STI prevention materials and outreach services. The project team then worked with local NGO partners to integrate messaging about health issues related to MSM and issues of unequal power dynamics into **street-theater productions**. In one routine popular with truckers, puppets represent a driver, conductor, doctor and counselor. Between the two truckers,

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it is the lowly conductor who is knowledgeable about HIV and other STIs and, as a caring individual, he accompanies his boss driver to the health center for STI services. The audience hooted and howled as power relations gradually shifted between driver and conductor, and at the end, they loudly applauded the conductor's wisdom and altruism. These productions created a safe space for project teams to begin discussions with both conductors and drivers about ways to stop or mitigate sexual harassment and coercion in their workplace.

Challenges

Discussions that arose from this modified body mapping exercise proved hilarious, energizing and thought-provoking. The discussions helped to make the truckers feel they were not alone in their experiences, while the facilitators came out of the exercises feeling more relaxed and confident in their ability to talk about sex, power and pleasure. Nevertheless, the exercises still made some people feel shy and embarrassed. Creating an environment where the truckers could feel safe to share their thoughts and feelings was a key challenge for the project. Furthermore, the facilitators had to learn how to encourage people to

speak and to give generous time for silences, allowing participants to think through and articulate these ideas for the very first time.

Lessons Learned

ISOFI staff realized the time investment required to make sensitive exercises like body mapping a success. One suggestion to create a more open environment from the outset is to do this activity after several other warm-up activities, ice-breakers or participatory activities, such as community mapping, which are less sensitive but also create an open, relaxed environment of critical thinking and reflection. Indeed, creating an exploratory, empathetic environment proved critical to the success of the body-mapping exercise, allowing both staff and the truckers to let go of judgments, which, in turn, led to more creative, effective programming.

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Republic of Georgia: Using Theater to Make Private Issues Public

What would it take to help the people of the small town of Guria, in the Republic of Georgia, talk about sexual and cultural issues long considered taboo? That was the challenge facing the Guria Adolescent Health Project (GAHP) as it set out to improve adolescent sexual and reproductive health (SRH). GAHP had decided not just to treat surface SRH problems like unplanned pregnancies and sexually transmitted infections (STIs), but to dig deeper, to go further in an effort to help the people of Guria deal with the underlying social and cultural issues fueling poor reproductive health among their young people. That meant creating a safe space for young people to talk to one another as well as their parents about cultural norms and values that had never been discussed, much less challenged. It meant helping the people of Guria voice the unspeakable. What GAHP found was that the best way to do this was to enable community members to bring their world to the stage.

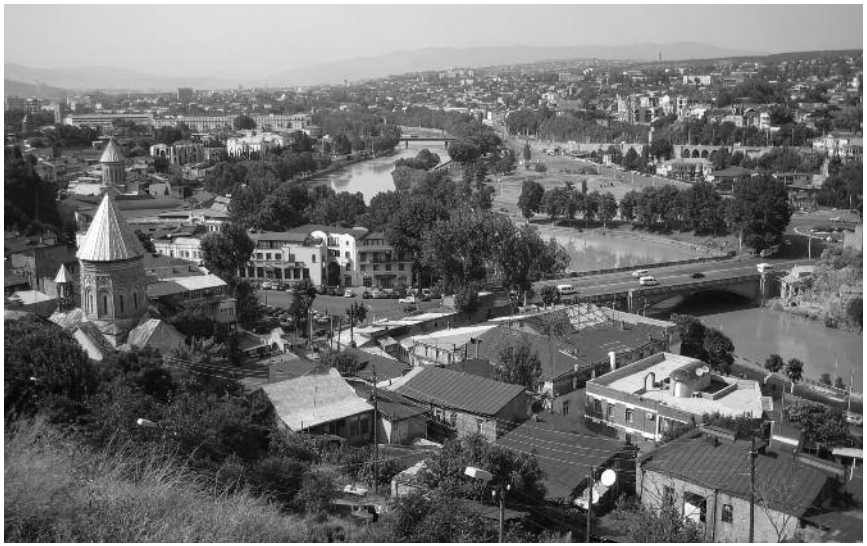
Background

Adolescent reproductive health is a taboo subject in rural western Georgia, where isolation, poverty and the strong influence of a conservative Orthodox church play key roles. The local culture of Guria is rich in tradition, much of which affects gender roles, relationship behaviors and even the meaning of words like "virginity" and "abstinence." For instance, while religion and culture promote the concept of abstinence before marriage, there is considerable difference in its application to boys and girls. As one female project participant noted, "Abstinence implies no close contact of any kind, not kissing or even coming within a certain physical distance. If this ban is broken, there will be no respect for the girl or woman." Essentially, girls may no longer be considered virgins if they break this taboo. For boys, however, the expectation is quite the opposite. Maturity and the transition to becoming a man is associated with a first sexual experience, usually well before marriage. Boys reported that they are encouraged to make this transition to manhood, especially through a sexual experience with a sex worker, at ages as young as 14.

Unplanned pregnancy and untreated STIs are common in Guria, but, within the context described above, adolescents are embarrassed to discuss SRH issues with adults. The result has been unsafe self-treatment, illegal and unsafe abortions, and even suicide. In the past, CARE projects like GAHP would have sought to deal with this issue by improving the quality of and access to adolescent SRH services. GAHP knew it had to do more to bring about a sustainable improvement in young people's reproductive health. So, in addition to addressing the knowledge, attitudes and behavior of adolescents ages 14-19 and the supportive behavior of adults (doctors, nurses, parents and other community adults), the project decided to tackle key gender norms affecting adolescent sexual decision-

making. On top of that, GAHP sought to strengthen adolescent life-skills in areas such as self-efficacy, decision making, negotiation and communication in order to help them to navigate the difficult path to adulthood.

The stakes for GAHP were incredibly high. Orthodox church leaders had shut down previous SRH (family-planning) projects because they believed that any discussion of family planning was contrary to church teachings. So, get it wrong and GAHP risked being closed down. Get it wrong and GAHP would put the lives of its staff and the families with whom it was working at risk.



Mona Byrkit/CARE

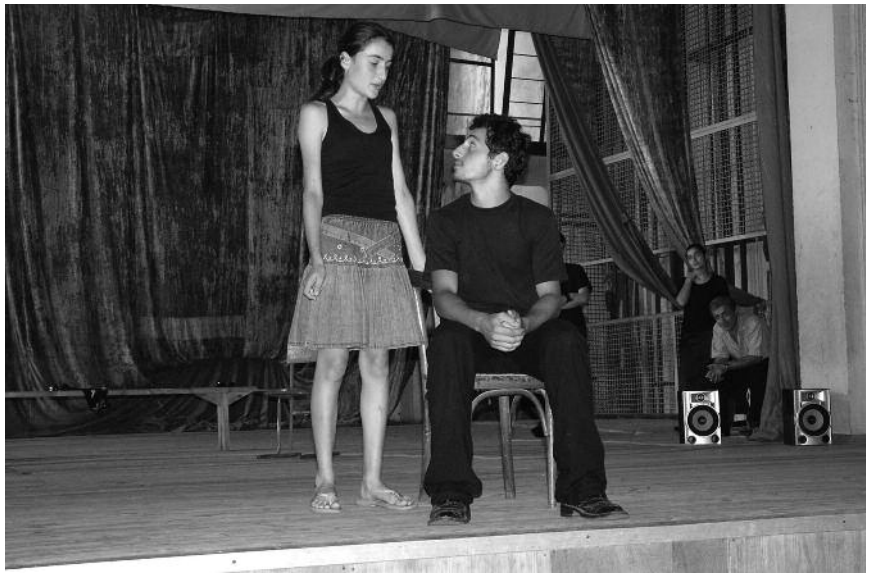
GAHP's Response

The answer for GAHP lay, somewhat ironically, in the very public forum of theater. Theater allowed GAHP to take issues considered intensely private out into the public, creating just enough distance from reality to feel safe. **Forum theater** proved to be a powerful yet socially acceptable way of discussing and questioning sensitive gender- and sexual-norm issues in a conservative cultural setting. The project staged performances that mirrored real life but were still, after all, just performances. This ultimately created the safe space needed for dialogue.

The idea that local theater could be used as a tool for social change came at a very early stage of this project. Although there was no experience of this kind in the region, Guria was fortunate to have a small professional theater troupe performing locally. GAHP and its local partners developed and produced short theater performances, developing fictional stories based on examples of real-life community experiences. Under the leadership of a professional actor as narrator, the actors showed the entire play to the audience. At the end of the play, the narrator "rewound" the play to the critical points in the action. In this dramatic phase, the actors used powerful "stop-action" poses to visually emphasize the key underlying causes of poor adolescent health in the community and to encourage the audience to recognize the potential for change at those crucial behavioral-decision points. At each stop point, the narrator encouraged the audience not only to give advice but also to take over the roles and show the rest of the community how it could be done differently. This generated debate among audience members and sometimes resulted in several different versions being acted out.

Perhaps one of the most powerful performances was called "**Closed Space**," which focused on exploring the social expectations of Georgian men and boys. GAHP had identified masculinity as one key, underlying cause of poor sexual and reproductive health. The play focused on what it means to be a "real man" in Georgia, asking audiences to reflect on equitable behaviors and attitudes, with respect for the rights of girls.

This methodology of asking audience members to come onto the stage and act out a new scenario proved particularly powerful for men; because it allowed them to physically enact a positive behavior in front of their peers, participants actually got the chance to practice behavior change. In one exit interview after a Closed Space performance, a man said, "When I was asked to come on the stage and play my version of the dialogue between a father and a son, I have realized that I can make a change."



Karen Robbins/CARE

What Happened as a Result?

Before these performances, many people in Guria believed that village opinions on gender issues were all the same, just as tradition had deemed them to be. But the performances and the debates they stirred demonstrated a wide variety of personal opinions among community members about the issue of girls' rights to make their own SRH choices, and about whether boys had to be sole decision-makers to maintain their reputations.

Seeing and hearing such diverse opinions gave confidence to those who had previously felt they were in a minority. In other words, the performances encouraged a more healthful respect for individual attitudes and actions. As a result, a small opening was created for family members to embrace behaviors that ran counter to tradition, to discuss sexual choices with one another, and, ultimately, to begin to redefine cultural norms to promote rather than prohibit sound adolescent SRH.

GAHP has gathered evidence that suggests some community norms about girls' right to choose are slowly changing for the better. One Guria council member and project volunteer observed that the custom of discrimination against a girl with an unplanned pregnancy was starting to change. "After seeing the play," he said, "people in our community showed that they had come away with the message that it is and should be a personal choice, not what the others in the village think." Another said, "There is increasing recognition that if a woman wants a relationship, it is her right. If a couple is in love, virginity does not matter so much."

Challenges

Encouraging and enabling a community to critically reflect on its norms and traditions and, in the process, air longstanding taboos is sensitive and painstaking work. Quick wins cannot be considered enduring changes, and thus commitment is required to see through the change process. Furthermore, ample time is required to lay the groundwork for the project to delve safely into sensitive subject matter.

From the earliest stages of GAHP, staff and partners spent considerable effort building supportive alliances as well as anticipating negative reactions and trying to manage them. Theater performances started only after the project had collected extensive information on the issues facing adolescents, developed objectives and activities, and introduced the project to key stakeholders, including village leaders, doctors, nurses, religious leaders and parents. For instance, GAHP took the strategic decision to preview Closed Space with an influential village priest prior to launching it in public.

Another key challenge involved preparing project staff and partners to address their own norms and expectations. Investing in staff capacity was absolutely critical to GAHP's effectiveness and legitimacy as a catalyst for dialogue. Because the project addressed gender and sexuality, GAHP prioritized these topics when developing a staff training schedule. An emphasis on the expectations and meaning of masculinity in Georgia helped reduce resistance to using gender equity as a key project concept.

Finally, the project faced the challenge of modeling precisely the kind of open dialogue that it sought to stimulate through its theater productions. Project staff and partners emphasized the value of open dialogue and the sharing of ideas throughout the project, including in the development of the play's stories, in the performances themselves, and in hearing community feedback for improvements. Ultimately, this **learning approach** greatly improved the quality of the project's interventions, because it showed that GAHP was willing to "walk the walk" of open dialogue, even in its own activities.

Nathan Bolster/CARE

Lessons Learned

In reflecting on lessons and key recommendations for others who may be interested in using these techniques, GAHP staff, partners and volunteers noted the following:

- **Learn from others:** "Study your culture well and you will find a lot of answers to many questions. You will also find many tools that will help you to achieve your goals as well as avoid conflicts and misunderstandings that may arise because of the sensitivity of the issues."

- **Work on the deeper issues:** "If possible, work on underlying causes! Use them as entry points, particularly where there are some central aspects of the project (SRH, family planning, etc.) that are taboo topics."

- **Be committed; it will test you:** "Do it with love for the job. If one can't experience this, then [one] can't do the job. A person should feel the issues themselves, and be eager for change."

Ultimately, one of GAHP's biggest lessons was just how effective theater can be as a catalyst for social change. Even the facilitators and actors have been surprised at its effectiveness as an educational tool. One project partner stated, "Theater is the most effective tool to communicate messages. People like art. Theater is a universal way to communicate."

The GAHP project showed that theater is a powerful way to communicate issues as well as to help audience members communicate with one another about those issues.

Section Four: Tools for Implementing Social Analysis & Action

Throughout this guide we have stressed the exploratory nature of SAA, and emphasized that your creativity and ability to respond to a community's specific context will contribute to successful SAA.

In this section, we have compiled several key tools that are useful when experimenting with SAA. Some of the tools may look familiar. We present them here to encourage you to build on your existing skills, to stimulate your thinking about different ways to implement SAA, and to give you a better sense of how SAA might unfold in practice. The aim here is not to suggest precisely how to implement SAA, but rather to ask "what if," as in, "What if you tried using some of these tools?"

Sarah Kambou/ICRW

Tools 1-3 can serve to orient CARE program staff and key partners on themes of gender and power, as well as provide a safe space for exploring values and practicing communicating around these themes.

Tools 4-6 can be useful for engaging communities, in order to collect data and stimulate discussions about social factors that may affect health.

Tools 7-9 allow a deeper exploration of gender, sexuality and social inequality. They challenge participants to articulate their beliefs, as well as confront social issues that may otherwise be surrounded by silence.

Tools 10-12 provide different techniques for reflecting on and monitoring progress, and identifying program areas that are either working well or need adjusting.

As you experiment with these tools, modify them to suit your own setting, inject your own experiences and approaches, or ignore them entirely to implement SAA as you see fit. In this way, SAA's ongoing growth and development will continue with you.

The tools included in this section can be seen as a companion to those presented in another guide CARE recently compiled, the ISOFI Toolkit. The toolkit captures knowledge and learning that emerged from the Inner Spaces, Outer Faces Initiative (ISOFI) that was piloted in India and Vietnam. ISOFI utilized many of SAA's exploratory approaches, particularly in the context of gender and sexuality. You can find the ISOFI toolkit online at: http://www.careacademy.org/health/isofi/welcome.html

Or you can download a pdf at:

www.care.org/reprohealth

Or you can order a copy by contacting Jaime Stewart at:

stewart@care.org

or

151 Ellis Street, NE
Atlanta, GA 30303

Please share your experiences utilizing and adapting these tools by e-mailing Jaime Stewart at stewart@care.org.

Tool #1: Ideal Man/Woman

Introduction

CARE is committed to overcoming gender discrimination. We often start training our staff with some basic gender-awareness exercises. Understanding that society's expectations for us as men and women are not necessarily related to our biological differences is a good first step to understanding how gender discrimination affects our lives, our programs and our project goals.

For purposes of Social Analysis and Action, this tool allows participants to explore how concepts of masculinity and femininity influence social dynamics in families and communities.

Objectives:

- To distinguish between "gender" and "sex"
- To explore the idea of socially defined gender roles
- To recognize gender stereotypes

Timeframe: 2 - 2 1/2 hours

Materials needed: flipchart paper, colored pens or markers; if available, materials such as clay or cloth for creating sculptures

Ideal workspace: All participants must be able to see the flip chart. For Part B, enough table or floor space is needed for groups of 4-5 people to draw large pictures.

Number of participants: 10-25; preferably similar numbers of men and women

STEP 1
Part A

Ask participants to think about the first words that come to mind when they hear the words "man" and "woman." Write down responses from the group in two columns on flipchart paper: "MAN" and "WOMAN."

This is an example of the kind of list that participants might come up with:

MAN		WOMAN	
Police	Noble	Cooking	**Menstruation**
Father	Breadwinner	Talkative	**Pregnancy**
Power	Beer, wine	Shopping	**Childbirth**
Strength	Makes decisions	Mother	Housekeeper
Freedom	Violence	Wife	Obedient
Businessman	Unfaithful	**Breasts**	**Vagina**
Penis	Husband	Gossip	Tolerant
Testicles	**Moustache, beard**	Sexy	Jealous
Generous	Lazy	Beautiful	Doesn't smoke or drink heavily
Selfish	Brave	Passive	
Dominant	**Adam's apple**	Tidy	**Uterus**
Loud	Humorous	Kind-hearted	Gentle

Make sure that, at a minimum, some words describing biological traits (such as "penis" for man and "breasts" or "menstruation" for woman) come up on the list. Biological components are bolded in the list on the previous page.

When the lists are complete, ask participants if any of the roles can be reversed. Can any of the "man" words also describe women? Can any of the "woman" words also describe men? What are the things that women or men can do exclusively?

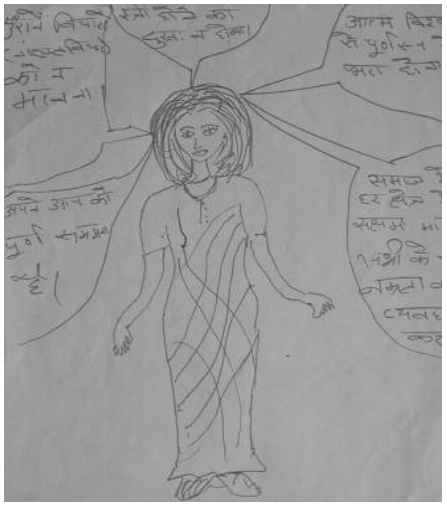
Can a woman be a police officer? A husband? A parent? Powerful? Free? Strong? Humorous? Generous? Breadwinner? Noble? Unfaithful? Can women drink? Can a woman have a penis? If women are capable of being a police officer (for example), why aren't there more women who are police officers?

Can a man cook? Do shopping? Be gentle? Submissive? Beautiful? Have breasts? Gossip? Be warm, kind-hearted? Menstruate? Be sexy? Be a wife? Can a man be fair? Be passive? Tolerant? Obedient? If men are capable of cooking and shopping, why don't more men do the cooking and shopping for their households? Why do some men who have jobs as cooks not do the cooking for their families?

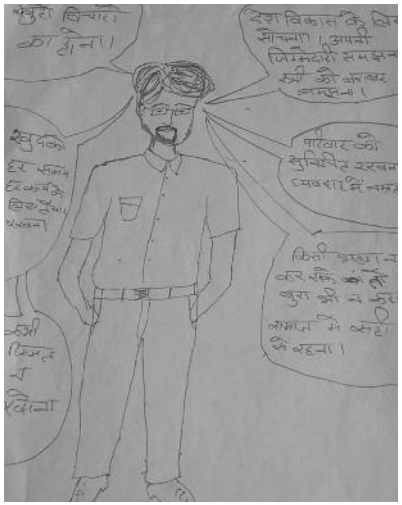
Explain that these lists illustrate the difference between sex and gender. Gender refers to the economic, social and cultural attributes and opportunities associated with being male or female at a particular point in time.

"I never understood all this gender stuff. Now I really see it. A village woman in Jarkhand is not allowed to touch the plow. That means that she can never earn the same livelihood like her husband."

– male CARE staff member, India



Sarah Kambou/ICRW



Sarah Kambou/ICRW

Part B

Divide participants into single-sex groups of 4-5 people.

Ask the groups to work together to illustrate what they understand to be an ideal man and an ideal woman in their culture, using large sheets of paper and markers.

Alternatively, if supplies are available, participants can use modeling clay, cloth, balloons, wires, pencils or other materials to build a sculpture.

Depending on the time available and the number of participants, you can ask each group to create two pictures or sculptures (one man and one woman), or only one picture or sculpture.

When they have finished, ask each group to present and explain their drawing(s) or sculpture(s) to the group.

These are some reactions of participants who completed this activity.

> *"By drawing an image of the ideal man, we realized that men also endure pressure and bear a different kind of discrimination by reinforcing gender inequalities." (women)*

"We men feel a burden to impress girls, earn an adequate salary and develop a muscular body." (men)

"I can't grow a mustache, and my father and uncle always pester me about it. I'm not considered [much of a man] without one." (man, India)

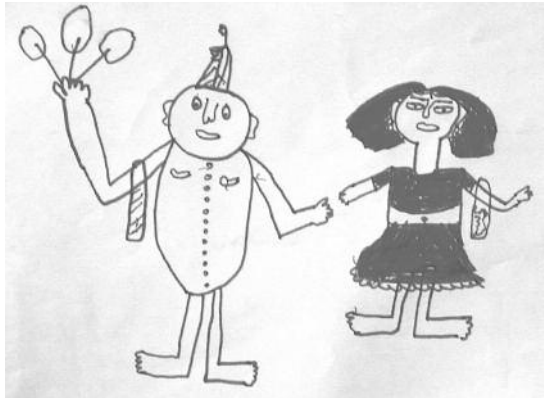
"It is so difficult to live up to the expectations of the ideal woman." (woman, Balkans)

"I feel enormous pressure to support my family financially. My dream was to return to school to get an advanced degree, but I had to give it up in order to fulfill my obligations." (man, Balkans)

STEP 2: Discussion

Initiate a discussion with the group using some or all of these questions as a starting point; ask additional probing questions as appropriate. Encourage debate within the group, and be ready to spend some time discussing the issues that arise.

Some sample answers are included beneath some of the questions to give you an idea of where the questions are headed. These are participant responses from a similar exercise that was done in the Republic of Georgia in 2006.



Sarah Kambou/ICRW

Sarah Kambou/ICRW

- What did you learn about being a boy or girl when you were growing up? How did you learn? From whom?

A newborn baby's sex is acknowledged when it is born when its genitals are recognized. Penis and testicles means it is a boy; vagina means it is a girl.

On identifying the biological sex of the child, the family knows how to bring her/him up. There are differences in the colors used for boys and girls (blue/pink), types of clothes (trousers/dresses), types of toys, etc. Social norms are set by each culture.

A person's biological sex dictates the way they will be brought up.

Boys are brought up to be independent, aggressive, tough, courageous, physically strong; girls are brought up to be dependent, emotional, sensitive, delicate.

- How are images of the ideal man and woman created? Where do they come from? Who affirms them? Would you like to change the images you describe?

The attitudes, values and behavior that as men we consider appropriate for us (our gender identity or masculinity) are learned in society.

Men can also be dependent and sensitive; women can be strong and independent. Society puts different values on these attributes for men and women.

More social value is placed on a newly born boy child than a girl child.

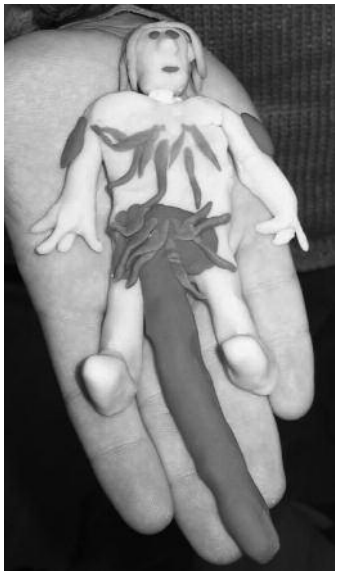
In the Republic of Georgia, the facilitator asked why none of the groups had included a penis and testicles in their models of an ideal man (see model shown on next page). Participants replied that it wasn't necessary since they were underneath the clothing. This

pointed to some nervousness and timidity with regards to exposing genital organs. The facilitator explained that in other countries, when this exercise was carried out, it was quite common for the groups to include penises and testicles, and there would be discussion around the size of them – some arguing that the bigger they are, the more of a man they are. This was acknowledged by some of the participants as being an issue for Georgian men, too.

J. Rosenzweig/CARE

- What are the things that women or men can do exclusively? (This question is deliberately open-ended. Participants may come up with answers that reflect biological or cultural differences.)

- What is a gender stereotype? Are gender stereotypes positive, negative or neutral? Why do gender stereotypes persist? What is the purpose of challenging gender stereotypes? Why do some people resist challenging the status quo?



M.Prvuloviç/CARE

- How easy or difficult is it to consider gender roles that are different from the ones we are accustomed to? What does this mean in the context of our development work? What happens if we challenge these roles? What happens if we do not challenge these roles?

STEP 3: Closing

Congratulate participants on their contributions and encourage them to become more aware of gender roles and expectations in their daily lives.

Ask participants: How do the concepts in this exercise relate to your work? How will your work change as a result of your new knowledge?

If appropriate, provide pieces of paper to each participant and invite them to write about how their understanding of gender has changed after this exercise. Also ask them to write down one action or change in their life they will make this week as a result of participating in this exercise. No one is asked to write his or her name on the paper, so it is anonymous. After everyone is finished, participants can volunteer their thoughts with the group.

"There is no difference between men and women except for reproductive functions, but there is social pressure to conform to particular roles. Both men and women are losing."

– male community member

"I have learned so much... I have been thinking and thinking of what was discussed and am able to see how discrimination happens between men and women."

– CARE staff member, Balkans

Notes to the Facilitator

This exercise explores what it means to be male or female in the participants' culture. It also challenges participants to think of gender as something that is capable of evolution and improvement.

Often, "gender" and "sex" are understood to be one and the same. In reality, they are quite different. There is a difference between what our bodies are physically able to do, such as producing sperm or giving birth, and what our society expects us to do.

Sex is determined by our bodies: A person is either male or female from before the moment he or she is born. Gender, on the other hand, is socially defined. Gender depends on historic, economic and cultural forces, and by definition is constantly changing. This means that people have different understandings of what gender is, depending on their context. People learn about what it means to be male or female from many places, including from their families, communities, social institutions, schools, religion and media.

The result of **traditional gender roles** is often that people are not able to reach their full potential. To **stereotype** is to categorize individuals or groups according to an oversimplified, widely-accepted image or idea. Both men and women would benefit from a perspective that does not limit what people can and cannot do.

For example, in many cultures, education for girls and women is given a lower priority than for boys and men. According to UNICEF, girls denied an education are more vulnerable to poverty, violence, abuse, maternal mortality and disease, including HIV/AIDS[1].

As another example, men in many cultures are expected to display traditional traits of masculinity. This can often result in sexual promiscuity, heavy alcohol consumption or violence, all of which are unhealthy behaviors, both for men and their families.

[1] State of the World's Children (2004).

All people can be "feminine" in some ways, and "masculine" in other ways. There is a diversity of masculinities and femininities that exist beyond the narrow gender models we are familiar with. **There is no one way to be a man or be a woman.** Our goal is to promote a flexible and tolerant attitude toward gender, rather than reinforcing rigid roles and expectations.

Gender is hierarchical; in most societies, it gives more power to men than to women. Also, it preserves the existing power structure. Work that women do revolves around the physical, emotional and social well being of other people, especially their husbands and children. Work that men do is related to their role as breadwinners/providers for their families, which leads them to seek out paid work. For example, many women love to cook, and many women cook better than men. Then why is it that mostly men are cooks at hotels and restaurants while women cook at home, unpaid?

We have found that it works well to **emphasize improving women's agency and autonomy, but not to the exclusion of men**. Working with men has shown us that if we work together to promote a wider definition of gender for both men and women – thus reducing discrimination and stereotypes for men and women who don't exactly fit the "norm" – everyone can be empowered. We need to keep working hard to find ways to reduce discrimination and allow more people equal choices and chances.

Often, society defines what is right for men and women. It is not our fault that the system is that way. However, **when we recognize that there is injustice, we can do something to change it**. Society is made up of people, and people are capable of change. This is a very personal process. First we have to recognize what is happening in our own lives, and then we can begin to make changes.

Most of us feel that culture, religion, tradition, and social norms dictate gender roles. But where does change happen if not in our individual circumstances? How does a fashion trend start if not by one or two people starting to wear or do a certain thing? Ideas about gender affect us both privately and publicly; that means we have the opportunity to make changes at both the personal level, as well as in society.

Tool #2: Silent Power

Introduction

We sometimes make assumptions that power is something outside of us. We assume that someone else controls us and the choices we are able to make. However, all of us use power at one time or another; we all have power at different moments in our lives. We negotiate power balances all the time with the people around us.

Some people define "power" to be "the capacity to bring about change." In fact, power takes many forms, comes from many sources and is measured in many ways. Power can be considered "positive" or "negative," depending on one's perspective. Understanding the many varieties of power is essential for those of us who work for social justice.

For purposes of Social Analysis and Action, Silent Power gets participants thinking about personal power, and how it may be possible to influence power balances in development settings. It is important that we use our own power to empower others, in a way that encourages others to make choices for themselves.

Objectives:
- To understand different kinds of expressions of power
- To identify ways to positively use different kinds of power, particularly in participants' work

Timeframe: 1 1/2 - 2 hours

Materials needed: flipchart paper, colored markers, prepared "Expressions of Power" flipchart pages

Ideal workspace: enough space for all of the participants to gather comfortably, and enough space to stage short skits in front of the group

Number of participants: 10-25; preferably similar numbers of men and women

STEP 1

With everyone in your group seated comfortably, ask participants to brainstorm examples of people or groups of people with "power." It is not necessary to write down responses. You might get such responses as:

a boss
people with money
people in politics
a crowd, a mob
a spiritual leader
teachers
the military, or people with guns
mothers/fathers
people of higher caste or class
men

Ask the group, "What types of power do these groups have? How do you know they are powerful?" You might get such responses as:

they control your decisions

they influence thought and ideas

they have weapons, they make people afraid

they create change

others respect them

they use their influence

they own property

they can help you, or not

they have the backing of a lot of people

they have self-confidence, they speak up

they can fire you

they do or say what they want

they go where they want

they have skills and knowledge

there are a lot of them working together

If you only get examples of people's power over other people, ask the group, "Do you think power is only control over others? What are some ways people can demonstrate 'internal' power?" You might then get examples such as:

self-confidence

courage

determination

refusing to do what they are told (2-year-olds, for example, frequently exercise this kind of power!)

If examples of the power of groups or collective action have not already been mentioned, ask the group, "Can you think of any examples of groups who exert power through working together?" You might get examples such as:

voters

crowds or mobs or gangs

unions

advocacy networks

Post the four Expressions of Power flipchart pages.

Expressions of Power

Power OVER – The power to dominate others. Power is seen as an external control over something or someone else. The source of "Power Over" is authority.

Power WITH – The power of mutual support, solidarity and collaboration; this comes when groups work together toward a common goal. The source of "Power With" is other human beings.

Power TO – The power that comes from the capacity to accomplish something. The source of "Power To" is one's knowledge, education, skills or talent.

Power WITHIN – The power of internal beliefs, attitudes and habits. This has to do with a person's sense of self-worth and self-knowledge. The source of "Power Within" may be self-confidence.

Jessica Wunderlich/CARE

One by one, read the four expressions of power. After reading each description, ask the group to think of examples of this type of power, and write them on the flipchart pages. Examples may come from families, workplaces, communities or other countries. Some examples are provided in the following table.

Different Expressions and Types of Power[1]

Expressions of Power	Sources of Power	Examples
OVER	Authority	The perception that a leader has the right to give directives and make rules
		Parents' authority over children
		Bosses' authority over employees
		Charisma that leads to the influence of famous or popular people
		Some social groups' power over others
WITH	Human resources or human supporters	People who support and assist a leader
		Groups who use collective action to achieve a goal
		Sense of identity or belonging
TO	Mental or physical skills, talent and knowledge	Education, talent, knowledge of a certain thing or how to do a certain thing
WITHIN	Habits or attitudes about obedience and submission, or sense of personal self-confidence, common faith, ideology or sense of mission	Habit of following what others say, believing that others are more capable.
		Strong sense of mission or destiny
		A two-year-old's willingness to say "no"

[1] Adapted from "Tools for Analyzing Power" from Just Associates (www.justassociates.org) and from Gene Sharp, Dynamics of Nonviolent Action: Politics of Nonviolent Action, Boston: Porter Sargent Pub., November 1985.

After the group has completed a list of examples for each category, facilitate a brief discussion about whether the group considers the examples to be a "positive" or "negative" use of power. Is it an appropriate use of power or an abuse of power?

The definition of "positive" or "negative" is debatable; it depends on the circumstances, and on one's perspective. For example, is a teacher's use of authority "positive" or "negative"? It depends on what the teacher is actually doing, and whether you are the teacher or the student! This is a good moment to clarify that the nature of "power" is not necessarily "good" or "bad" because it can be either. Even authoritarian power (or "Power Over") can be extremely useful and necessary, in the case of parenting, for example.

STEP 2:

Divide participants into four groups. Each group will enact a short skit of no more than 2-3 minutes in front of the other three groups. Explain that each skit will portray an expression of "power" without using words.

Assign each group one expression of power:

Group 1: Power OVER
Group 2: Power WITH
Group 3: Power TO
Group 4: Power WITHIN

Instruct the groups to portray how its expression of power plays out when staff interact with community members. Give the groups 10-15 minutes to prepare their skits.

STEP 3: Discussion

When all four groups are ready, ask for volunteers to portray their skits. After each group's skit, facilitate a discussion, based on the following discussion guide:

- What is the story that you saw? Can anyone summarize? (Ask the skit players whether these summaries were accurate.)
- What happened as a result of the power enacted? Were you surprised by the result?
- Is there any way that the situation would have turned out differently if any of the characters had used a different expression of power? For example, if someone had used "Power To" instead of "Power Over"? Or "Power With" instead of "Power To"? Does anyone from outside this group have any suggestions for the group for another alternative line of action to achieve a different outcome?
- Was the expression of power positive or negative, from the perspective of CARE's vision of ending poverty and injustice, or from the perspective of the most vulnerable participants of CARE's programs?

After all the skits have been presented and discussed, facilitate a discussion based on the following discussion guide:

- In our work (for example, as CARE employees), when we enter communities for our jobs, do we perceive ourselves to be more powerful or less powerful than the people living in the communities? Are we perceived as powerful by others? If so, by whom?
- As development workers, what kind of power do we have? What kind of power do we use? As development workers, are we using our power to combat injustice or fight unequal power dynamics? What kind of power are we routinely using? Is it Power Over, Power With, Power To or Power Within? Some probing questions could be:
  - Do we have power over others in the community? Can we use our influence with people like the police, or with the Ministry of Health? Will they listen to us?
  - Are we working to build opportunities for people to work together collectively?
  - Are we better educated or do we have different skills than others who we are working with? Are we helping others to acquire new knowledge or skills?
  - Are we working to help build people's self-confidence, or improve people's sense of capacity to create change?

Finally, instruct participants to pair up and discuss the following question for 2-3 minutes:

> *"How can we improve the way we do our jobs so that we build on our project participants' Power Over, Power With, Power To or Power Within? What are some ways to incorporate these into our current project or objectives?"*

Ask the pairs to briefly share one example that they discussed with the entire group. Write these examples in a new color on the flipchart pages listing the different expressions of power.

STEP 4: Closing

Hand out pieces of paper to each participant and ask them to take 5 minutes to think about their own use of "Power Over," "Power With," "Power To" and "Power Within," either at home with their families or in their work with communities.

Ask each person to write one way they would like to use their own personal power in a new manner in the next three months, in response to a challenge in their personal lives or at work. Tell them that this is for their own personal use, and no one else will see it. When everyone is finished, ask if anyone wants to volunteer to share their own resolution with the group. Thank them for that when they are finished. Congratulate everyone on a job well done.

Notes to the Facilitator

The concept of power is quite difficult to define. Many academics have tried to describe all the different types of power, sources of power, expressions of power, etc. This exercise simplifies the concept of power, so of course participants may come up with arguments or suggestions for examples that seem to fall outside the neat categories shown. That's all right; it's good to debate a little.

One of the main points of this exercise is that power is just power; it is not necessarily good or bad, although it can be used both constructively and destructively. As people who work for a development agency, we need to be aware of the power that our position provides to us as individuals, and how we can use that power constructively in community settings. Getting together with colleagues and thinking about where power comes from and how it is used could help us think creatively about how to identify negative uses or expressions of power and transform them into constructive ends.

Participants may have emotional feelings about a power discussion, because it's often seen as negative, especially if participants are remembering a time when they felt powerless. There may be some uncomfortable moments in this exercise because of that. Be prepared for it and to allow people to not participate if they so choose, and/or to take some time away from the discussion if they need to. Don't let other participants bully them into sharing what they don't want to share. Be prepared to provide some quiet moments of discussion with these participants after the exercise is over. Be prepared to provide referrals to counseling if people would like that.

For additional resources on power and using personal and group power constructively in community development settings, the following resources could be useful:

A New Weave of Power, People & Politics: The Action Guide for Advocacy and Citizen Participation, by Lisa VeneKlasen with Valerie Miller, Stylus Publishing, 2002. You can find chapters from this on the Just Associates web page: http://www.justassociates.org/ActionGuide.htm

Tools for Analyzing Power: Exercises to Help Groups Understand and Analyze Power, from Just Associates: http://www.justassociates.org/publications_files/toolsforanalyzingpower.pdf

The Beyond Intractability web site provides resources for ways that power can be analyzed and utilized to equalize power in situations of social injustice. See more details at: http://www.beyondintractability.org/user_guides/third_side/equalizers.jsp?nid=5134

Tool #3: Fishbowl

Introduction

Fishbowl is a good way to help program staff explore, articulate and analyze their personal feelings about social issues that are rarely discussed publicly.

For example, this tool has been used to facilitate a discussion about inadvertent discrimination in the workplace. Before the exercise, many participants did not even realize that this was an issue. The act of public sharing created a bond of solidarity within the group, and transformed some people's awareness of how they may have been contributing to workplace discrimination.

Fishbowl works well as a follow-up to the Ideal Man/Woman and Silent Power tools; participants can share their personal experiences around issues of social inequality that arose during the previous tools.

Objective:

- To openly discuss and analyze personal feelings about social issues

Timeframe: 1 hour

Materials needed: none

Ideal workspace: enough space to create an inner and outer circle of chairs

Number of participants: 10-15

STEP 1

Form two circles of chairs to create a "fishbowl." The inner circle should contain 4-5 people who are willing to share their experiences. The rest of the group forms the outer circle, and listens to those in the inner circle as they share their experiences. The people in the inner circle face one another and speak to one another; they do not physically interact with the outside circle.

Suggest a theme, such as facing discrimination based on ethnic group. People in the inner circle share their experiences with one another, and can ask questions and offer encouragement to one another.

STEP 2: Discussion

After the discussion among the inner circle has come to an end, the facilitator asks people on the outside for their observations and reflections. The objective is to have a very honest discussion about what it means to be socially excluded. The discussion can include sources of social inequality, ways that social inequality takes place, the effects of social inequality, as well as ways to combat social inequality.

STEP 3: Closing

Congratulate participants on their contributions, and encourage them to continue exploring and sharing their personal experiences with their colleagues.

Ask participants: In what way has this exercise affected you? What have you learned as a result of this exercise? What will you do differently as a result of this exercise?

Notes to the Facilitator

This can be a very powerful and emotional exercise. Be sure to establish ground rules with participants at the beginning of the exercise about listening respectfully and maintaining confidentiality.

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Tool #4: Problem Tree

Introduction

Problem Trees are used to visually analyze the underlying causes of a specific health issue. Although Problem Trees often identify social and cultural factors as constraints, these factors are usually not analyzed more deeply than simply naming them.

For purposes of Social Analysis and Action, Problem Trees help participants to "unpack" the underlying social and cultural factors that lead to negative health and/or reproductive health outcomes, and to develop actions to address these factors.

Objective:
- To identify and analyze social and cultural factors that affect health

Timeframe: 1 1/2 – 2 hours

Materials needed: flipchart paper, colored pens or markers

Ideal workspace: enough space for all participants to see the flipchart paper

Number of participants: 5-10 people per group

Process

Start by reminding the group of one major health problem that they had identified in previous discussions. Note the problem, either in words or with a symbol, at the top of a flipchart page.

Next, draw a tree, incorporating the words or symbol into its trunk, branches and leaves. Show the roots of the tree reaching down in several directions. Suggest to the group that the community's problems are like a tree, and that the causes of the problems are like the roots reaching deep into the ground.

Ask group members to think of things that may be at the cause of the problem. As different ideas are shared, note them on the roots of the tree (either in words, symbols or drawings). As each cause is identified, ask why it is a cause. Be sure to give participants time to reflect and discuss their responses.

After allowing for a break in the discussions, reconvene participants and ask them to take a new sheet of flipchart paper and place one of the social causes from the original problem tree at the top of the paper. This will usually be noted using words like "socio-cultural factors" or "traditions."

Repeat the exercise, but focusing on the causes of existing socio-cultural factors. As each cause is identified, ask why it is a cause, giving participants time to reflect and discuss their responses.

Finally, when the full complexity of the social issues and their causes is clear, ask the group to suggest possible solutions to some of the causes they have identified.

Notes to the Facilitator

This exercise was used in Sierra Leone at the beginning of an adolescent sexual and reproductive health program. After the first round of Problem Tree analysis, participants noted that all groups noticed culture, society and tradition as being important factors in early marriage and unintended teen pregnancy. Focusing a second round of analysis on these social factors allowed for long discussions on social issues that affect young people's sexual and reproductive health. The discussion was vast and informative. Some of the issues mentioned were:

- Older people cannot talk to youth about sex at all. Information on sex and reproductive health is given by secret societies.
- If someone is not initiated into a secret society, he or she and his or her family experiences stigma and marginalization. Societies can drive people away if they do not conform to defined behaviors.
- Marriage between the ages of 14-18 is expected of girls because of religious and/or cultural factors. Early marriage is most common among girls who do not attend school. The girl's family identifies her future husband.
- If a girl gets pregnant before her initiation, she must leave the community. Parents must pay if the girl loses her virginity; however, parents don't mind when boys lose their virginity.
- Culture requires girls to be circumcised.

Much of the conversation focused around the secret societies, the importance of initiation of boys and girls into secret societies, and that secret societies played key roles in providing sexual and reproductive health information and guidance. Despite not being able to talk openly about secret societies (participants had been initiated and had vowed to not discuss the inner workings of the societies), participants agreed that there were ways to approach communities to talk about youth and sexual and reproductive health and that the societies should be informed, even if tacitly, of the program's planned activities.

CARE

Tool #5: Social Mapping

Introduction

In this exercise, participants are asked to identify what they consider to be sources of social and institutional support within their community. Participants are also encouraged to consider social and gender status in relationship to access to resources.

This activity is also a good way for development workers to obtain valuable information on resources that are already present in the community, as well as get a sense of what additional resources might be needed.

Objective:

- To explore how social status may determine a person's mobility and access to community resources

Timeframe: 1 1/2 – 2 hours

Materials needed: flipchart paper, colored pens or markers, tape

Ideal workspace: enough space for all participants to see and write on the flipchart paper

Number of participants: 10-15; if more participants are present, break them into smaller groups and have them create multiple maps

STEP 1

Distribute markers to all participants.

Ask participants to work together to draw a map of their community. If they have never seen a map, explain that you are asking them to imagine how their community would look to someone flying over it, and draw that image on the paper or on the ground.

Some participants may not be accustomed to using a writing utensil, so encouragement and patience are needed. One alternative is to clear an area of dirt or sand and ask people to create a map using objects found in nature, such as rocks, sticks or grass.

Reassure the participants that things do not have to be drawn exactly – the map is only to get a general idea of what the community looks like.

Ask the participants to draw all of the resources in the community. Explain that resources are buildings, organizations, people or services that are available to the community when they are needed. Resources can mean: roads, houses, health facilities (health posts, pharmacies, hospitals, clinics etc.), schools, religious buildings or leaders, water wells, public baths, markets,

schools, factories, rivers, trees, midwives, social workers, teachers, doctors and so forth. Ask them to identify the various community resources by name or with a symbol (or an object, like a twig, if maps are made on the ground).

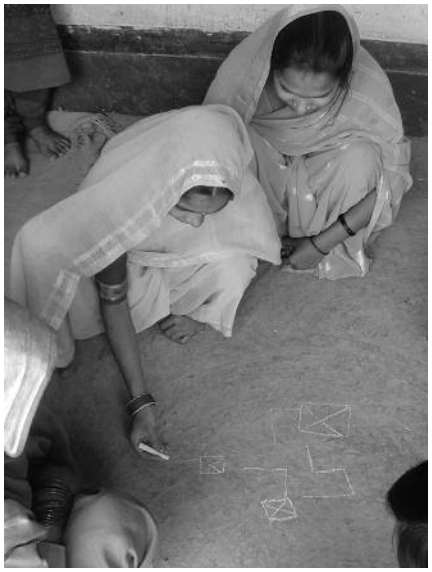
Ask participants to mark where different groups in the community live (the wealthy, laborers, different religious groups, different ethnic groups, original settlers, people who arrived later, etc.). If sex workers are not mentioned in the groups of people identified by the community, ask about sex workers and where they live.

Be careful not to direct what is being presented and how it is being presented.

STEP 2

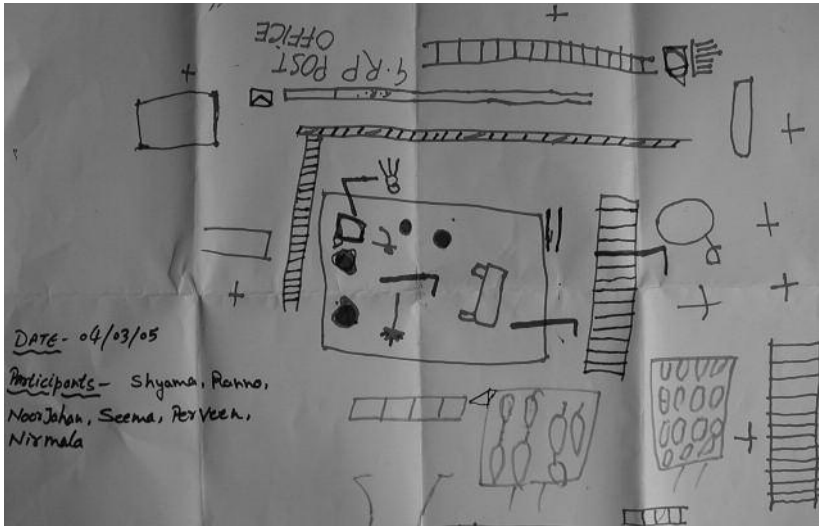
Lead a group discussion about the map that explores issues of mobility and access to resources. Ask probing questions to draw out more information from the map(s). If more than one map was drawn, point out similarities and differences among them. Facilitate a discussion with the group. You can use the following questions to guide you.

- Are you surprised by the amount of resources in your community? Are there more or fewer than you had thought?
- Which places or resources can be visited by anyone in the community?
- Are there any places or community resources that certain people might feel uncomfortable or unsafe visiting or using? Can you identify these places and resources on the map?
- Do you think there is a difference between what men experience in some places and what women experience in the same places?
- Does a person's caste, gender, ethnicity, age or education level determine the places they can go in the community? Does a person's caste, gender, ethnicity, age or education level affect how they are received or treated in different places?
- How do class, caste, religion, gender, age and disability influence a person's mobility or access to resources within the community?
- Within the community, how does a person's sexual reputation affect their mobility and their access to resources? Why?



Sarah Kambou/ICRW

- Whose mobility is generally more restricted? Whose mobility is generally less restricted? Why is the mobility of some restricted while the mobility of others is not?



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Tool #6: Focus Group Discussions

Strategically identifying and speaking with different groups of people allows us to better understand meanings, values and perceptions relating to a particular issue. Listening to people talk about sensitive traditional issues, such as early marriage, in their own words also confers respect and builds trust between outsiders and insiders. Furthermore, discussing issues in a public space can help mobilize people around an issue that is usually not discussed publicly.

Focus group discussions (FGD) have always been part of PLA. For purposes of Social Analysis and Action, FGDs can reveal what people think about sensitive issues such as human rights, as well as responsibilities to uphold certain rights. Through FGDs, we can use an ethnographic line of questioning to learn about social customs that directly influence sexual and reproductive health.

Objective:
- To better understand meanings, values and perceptions relating to a particular issue

Timeframe: 1 – 1 1/2 hours

Materials needed: notepads and pens to record key points of the discussion

Ideal workspace: enough space for all participants to gather comfortably

Number of participants: 5-10

Example 1: Rights and Responsibilities FGD

As we were beginning a multi-country rights-based FGC abandonment project (in Ethiopia, Sudan and Kenya), we decided we needed to know what people thought about rights and responsibilities regarding good health and whether people associated FGC with rights violations. We were not at all sure what we would hear, and were delighted that people really wanted to talk about this issue.

We began with the human-rights language used in legal rights conventions, although we all know that that kind of language is not used in everyday settings. It is helpful if facilitators have a basic understanding of international language on rights, such as the right to the highest standard of living and the right to health, so that these concepts can be discussed in the local language. We worked with counterparts to find the best local words for "rights" and "responsibility for upholding rights."

Were there specific words in local languages that signified rights and responsibilities to uphold rights? (Yes.) Would ideas differ across ethnic groups? (They were remarkably similar.) How would people define those people or groups who were responsible for upholding rights? (It was mostly defined from religious doctrine.)

The composition of the focus groups depends on the subject matter. We had groups of men, of women, of adolescent unmarried boys, and adolescent unmarried girls. Bringing men and women together created some uncomfortable moments when it became clear to everyone that women had fewer rights. However, both sides were given the opportunity to talk with each other about inequalities, something they had probably not done in the past.

Question Guide

- Most of us agree that people should live as good a life as possible. What does a good life mean to you?
- You have mentioned that to have a good life means that one must be healthy. Do you think that women are as healthy as they can be? (Men were asked about men, and children were asked about people in general)
- What are examples of "good health?"
- Do you think that women should have a right to be healthy? Why do you say that?
- Do you think that other members of your family (like husbands or children) have a responsibility to make sure that women in the family have good health? Why do you say this?
- Do you think that your community has a responsibility to make sure that women in the community have good health? Why do you say this?
- As women, what rights do you have? What examples can you give?
- What rights do your children have?
- Are there differences in rights between men and women? Between women and girls? Between boys and girls?

In the future, if we did this FGD again, we would add another set of questions to understand traditional mechanisms used by communities to handle the denial of rights. Such structures exist but we did not ask about them. Our work is showing that even with such structures, judgments are on a limited set of issues that do not normally include women's rights.

Example 2: Rites, Customs and Kinship/Marriage Traditions that Relate to Sexual and Reproductive Health

An anthropologist, who was an RH project manager in Ethiopia piloting FGC abandonment activities, used an ethnographic approach to learning about FGC. Talking with people about marriage customs and kinship issues eventually led to discussions of social factors that influence sexual and reproductive health, including taboo subjects such as female genital cutting. Taking this indirect approach was very valuable, as we learned about marriage and its larger social meanings, as well as how cutting fit into the broader social context.

In this situation, we worked with counterparts to develop a plan for how to enter into discussions with different groups of people about marriage, kinship and other social relationships. We agreed that FGC would not be brought up by the facilitators. If people brought up the practice, then we would have "permission" to talk about it. Having an anthropologist in this situation was a great help!

Question Guide

- What customs surround marriage (e.g., exchange of gifts, celebrations, religious or other ceremonies)? Why they are important?
- Who decides that a couple should marry and when they should marry?
- What roles do mothers, fathers, in-laws and community leaders play in marrying in your family?
- When is a girl ready to be married? When is a boy ready to be married? (Probe for age, physical changes associated with puberty, economic status, lineage and promised marriages, etc.)
- Are there couples that should NOT marry? Why?

If FGC is mentioned as a requirement for marriage, then a set of questions can be asked, including:

- How is FGC practiced in this community? How widespread is the practice?
- Why do people think that it is important to practice FGC in this community? (Probe for values and traditions associated with FGC. Who [individuals or groups] in the community has strong opinions on FGC?)
- What do you think about the practice? Do some people want to change the practice? Do some people want to keep the practice? Is it a good thing? A bad thing? Both good and bad? Why? Do you think that the practice will change?

Ami Vitale/CARE

Tool #7: Body Mapping

Introduction

The concept that community members are experts in understanding their own health needs and social realities is fundamental to social analysis. Community members use Body Mapping to better understand and articulate their relationships to their own bodies and to sexuality in general. Using this tool with different groups such as truck drivers, youth, sex workers and people living with HIV and AIDS allows a fuller understanding of the social realities and health needs of diverse community members.

This tool emphasizes the need to incorporate the language and images that are familiar to each culture in order to develop educational materials and approaches that reflect the culture of the community.

This body mapping tool is a modification of the classic tool by the same name.

Objectives:

- To become more comfortable speaking about body parts in the context of sexuality
- To discuss body parts as sources of pleasure, pain, shame and power

Timeframe: 2 hours

Materials needed: flipchart paper, colored markers, notepads, pen, pencils, tape

Ideal workspace: enough space for participants to create several life-sized drawings

Number of participants: 10-25

STEP 1

Divide participants into single-sex groups of 5-6 people. Ask for one volunteer in each group to trace the body shape of another participant.

Ask the participants to identify, draw and label the various reproductive and sexual body parts.

Ask the participants to locate and mark with different colored markers the parts in the body that give them pleasure, pain, shame and power.

Sarah Kambou/ICRW

Three groups of participants who did this exercise came up with the following responses:

Group One	Group Two	Group Three
The head can be a source of power, shame and pleasure Eyes: power, pain Breasts: shame (covering this part), pleasure, pain in menstruation and childbirth Ovaries: pain Vagina: pleasure, power, pain, shame Anus: shame, pleasure and power. Feet: pleasure Discussion: Men and women have these feelings in different places. Also, individuals vary in where and how they feel pleasure, pain, power and shame.	Brain: all of the feelings are in the brain Eyes: power, pain, shame (seeing something one doesn't want to see) Mouth: power, pleasure Neck: pleasure for the woman Breasts: power associated with breastfeeding Heart: all four Reproductive organs: power, shame Genitalia: all four Feet: pain, pleasure Hands: power in work Anus: pain, pleasure and shame	Pleasure can be experienced all over the body for both males and females The woman suffers more pain than the man: head, heart, vagina, reproductive organs, breasts and the back The man: pain in the reproductive organs, head, heart and the anus Power: women have power in certain terms; men have overall power in their bodies. Shame: associated for women with menstruation, breasts

STEP 2: Discussion

Facilitate a discussion with the entire group using the following guiding questions:

- How did those whose shapes were traced feel? How did those who did the tracing feel?
- Why did you feel power (or pleasure, or pain, or shame) in these areas you marked?
- When do you experience power (or pleasure, or pain, or shame) in these areas?
- How do you experience power (or pleasure, or pain, or shame) in these areas?
- How do you use your own power with your sexual partner?
- Are there different attitudes and judgments that are attached to different body parts? How does this impact how we feel and think about sex?
- Are there some body parts that feel powerful to some? Are those parts used for power over others?
- How are those areas that you feel power in related to feelings of pleasure, pain and/or shame?
- Why is it that some body parts can give us power as well as shame?
- What causes us to feel shame?

Notes to the Facilitator

The large group discussion after the exercise will reveal how individuals' experiences differ. Facilitators have noted that some people volunteered to be drawn, while others had to be chosen. Some people felt shameful being drawn. One did not, but felt shamed by how his body was represented. One woman felt more comfortable being drawn by a woman rather than by a man. Another woman felt more comfortable being drawn by a man. Often in body mapping, a woman does not want a man to draw the lower half of her body, but doesn't mind if he draws the top half.

When this exercise was conducted with a group of people living with HIV/AIDS, the facilitators noted that group members were very supportive of one another during the activity. Everyone took turns with the pen and joined the drawing. Before and during the drawing, there were interesting discussions among the group.

The youth group demonstrated talent in drawing. However, girls were shy to draw sexual organs because they said that they were taught to wear clothes to hide their bodies. Girls claimed that all parts of the female body could feel pleasure. But they were not sure how the body could feel power because they said they lacked experience in having sex.

Among the group of truck drivers and conductors (younger men who assist the drivers with passengers and freight), there was much debate over the origins of sexual pleasure. Some believed pleasure originates with the eyes – through sight and visual stimulation – and then travels to the heart and eventually the mind. Others contend that pleasure emanates from the heart – through love and emotional attachments – and is amplified throughout when it reaches the brain. The majority indicated that the penis was the source of pleasure, and that the power of the penis is essential to a man's sexual being. The truck drivers, who were generally older than the conductors and more likely to be married, focused on the penis not only as an instrument of pleasure but also of power. Participants touched upon various penis myths, for example that the penis expels energy and heat from the body during ejaculation. If ejaculation is controlled or eliminated altogether, energy builds up reserves in the body and is converted into enormous strength. Finally, the truck drivers related the power of the penis in terms of its ability to pleasure a woman. Size of the penis was not as important as endurance and performance while performing the sex act. One man said if a man cannot satisfy his woman, "he feels like dying; there is no point in living."

In a group of female sex workers, the vagina was the main symbol of power. "We know men revolve around our bodies. We can have them in our control if we want." For most of them, the ability to conceive and bear children was also powerful. For most of them, breasts, lips and vagina were parts of the body they associated with pleasure. For some, discussion around pain meant physical pain, and they identified the vagina as the part of the body that gives the most pain. This pain happened during menstruation, and because of the nature of their work. "Sometimes we see too many clients in a day and other times the clients are very rough with us. This causes immense pain." Others referred to experiences that gave them emotional pain. For them, shame was basically in the mind. "It is what you think and see that brings shame. There is no shame in the body." However, they all felt that there was shame in their profession. This shame is responsible for their low self-esteem as well.

Tool #8: Crossing the River

Introduction

In Crossing the River, storytelling is used to polarize the group, as they are asked to make a choice involving sex.

This tool examines social position and how it influences our perceptions of power, and it challenges participants to examine their beliefs on gender and sexuality.

Objectives:
- To challenge participants to examine their beliefs on gender and sexuality

Timeframe: 1-2 hours

Materials needed: none

Ideal workspace: enough space for participants to gather comfortably

Number of participants: 10-15

Process

Read the following story to the group:

> *A woman goes to buy her vegetables every day from the market across the river, and then comes back home to her husband. One day she crosses the river to get her vegetables and falls in love with another person. After she meets this person, she still goes to the market every day, and every day returns to her husband. One day there is a massive thunderstorm that has swollen the river and she cannot return across the river to get home her usual way, stepping across the rocks. It is getting dark. She has three options:*
>
> > *(1) Swim across the swirling, fast river, but she will almost certainly die.*
> >
> > *(2) There is a boatman who can take her across the river, but he will only do it if she has sex with him first.*
> >
> > *(3) She can walk the long way through the forest but there is a man, an un-convicted rapist, living there and he may rape her.*

Ask participants, "If you were this woman, which would you choose to do and why? What would you say to convince others to agree with your decision?"

Notes to the Facilitator

This exercise was conducted in Vietnam with CARE staff to create a strong foundation for integrating concepts and "lenses" of sexuality and gender in CARE's sexual and reproductive health programs. This exercise challenged participants to examine their beliefs and notions on gender and sexuality. Discussions following the exercise focused on choices that one makes in life and how these are intimately linked to social constructions of gender and sexuality. This exercise helped participants to make the link between programming and perceptions, which led them to explore ways and means to integrate gender and sexuality into program implementation.

In Vietnam, participants gave the following reasons for their choices:

- ***Swim***

  No one in the group chose to swim and face almost certain death.

- ***Boat and Boatman***

  Because I do not want to die, and do not know what risk there is in the forest.

  I feel like I can control the choice, rather than being forced to do something. I am both safe after crossing the river in the boat and I have controlled the choice.

  There is a natural instinct to survive: I would do anything to live.

  If the woman has betrayed her husband, what does it matter with whom she sleeps?

- ***Forest***

  I would rather choose uncertainty – maybe he won't rape me.

  I could fight the rapist and maybe survive. To have sex with the boatman – someone I don't like – is the same to me as getting raped.

  Given that I might not get raped by the accused rapist in the forest, I would choose that slim chance rather than the certainty of sex/rape with the boatman.

In the discussion that followed, participants brought up many important points:

We assumed that the person she fell in love with was a man, which is not necessarily true.

We also assumed she was having sex with this person. But she fell in love, and she may have only been talking to the person she loved. Is this betrayal?

Some people feel it is better to die than to be raped. But if you had a child waiting for you, would you risk death?

Those who chose to pass through the forest: We hold onto the hope that because he was not convicted, he was not really a rapist; or that he might be sleeping; or that we could successfully fight him off. We are willing to take that risk. Is it perhaps that it is easier to go back home and say I was raped, than to go with choice #2?

These choices are similar to the ones we make in real life – none of the choices are clear-cut.

What if we had reversed the story and said it was a man who needed to cross the river? Would our assumptions have changed? Would a man consider jumping into the river? What does it mean for a man having sex with another man against his will? Would he rather negotiate this or take the risk of being raped?

Sometimes a woman's honor, chastity or morality seems more important than her life. Can you imagine a woman preferring to tell her husband she had been raped, rather than telling him she agreed to have sex to survive?

A Vietnamese man might choose choice #2 for his daughter, #3 for his wife. The wife is an extension of her husband's honor. Sometimes we go to great lengths to control women's sexuality in order to protect men's honor.

These choices are about negotiating power. We all do this constantly.

Tool #9: Values Clarification

Objective:
- To reflect on personal attitudes and values around commonly held beliefs

Timeframe: 1-2 hours

Materials needed: Signs that say "agree," "disagree," and "not sure." If participants are not literate, make signs with (1) a smiling face; (2) a frowning face; and (3) a face that looks puzzled.

Ideal workspace: Enough space for people to move about freely. If necessary, move tables and chairs out of the way. Place your "agree" sign at one end of the room or space, and the "disagree" sign at the other. Put the "don't know" sign in between, in the middle.

Since it may take more than an hour to complete the exercise, it may help to place some chairs at either end of the room, under the "agree" and "disagree" signs.

Number of participants: 10-25; preferably similar numbers of men and women

Introduction

This tool challenges people to articulate and examine their values and attitudes about commonly held beliefs. Often we are unaware of our own biases. Sometimes our beliefs have a rationale; other times, they are a product of our surroundings and may persist until we question them and begin to imagine an alternate reality.

Hopefully, this exercise exposes participants to people with differing opinions. If facilitated well, it helps people understand that there are a wide variety of opinions in the community, and that each person has a right to his or her own opinion. It should also open up a respectful space for dialogue on topics that are commonly considered taboo, so that people can state an unpopular opinion or ask difficult questions, but still be respected.

STEP 1

Describe the activity and its purpose. Tell participants that this is a group learning exercise where everyone in the group gets to give their opinion on things that society expects of us. The purpose is to allow everyone participating to reflect on their personal attitudes and values around commonly held beliefs. The goal is not necessarily to convince anyone of anything, but to encourage respectful debate.

Although everyone in the room will not agree on everything, it's important that everyone in the group receives respect. Participants should refrain from judging, interrupting or ridiculing others. Participants should respect the privacy of others by not repeating what someone said afterwards, and especially not to say who said what during the exercise to anyone else.

Explain how the exercise works. You, the facilitator, will read out a series of statements (tell them how many you plan to use) that reflect an opinion or value. Then each person has a chance to decide whether they agree with that

opinion or not. If they completely agree, they should stand under the "agree" sign. If they completely disagree, they should move over and stand under the "disagree" sign. If they are really not sure, they can stand somewhere in the middle, depending on how unsure they are. For example, if they mostly agree, but not completely, they can stand half-way between "agree" and "not sure." They should feel free to move from one spot to another as they re-think their own opinion. They should also feel free to "sit out" the question and not participate at all, if they so choose.

STEP 2

One by one, read out opinion or values statements and ask participants to respond by moving closest to the sign that corresponds with their personal feelings.

Move through the questions slowly. After participants have moved to a part of the room, conduct a short discussion about why they chose to agree or disagree. First ask for a volunteer among the group that has a majority of participants to explain why he or she felt the way they did. Then ask if anyone else has anything to add. Turn to the group on the other side and ask the same.

Use probing questions to dig deeper into the underlying issues. Allow some time for debate between people of differing viewpoints. After a short debate, ask people if they would like to change their position, or if anyone in one group wants to convince people in another group to change positions or move closer to their position.

The following statements are some examples of values statements, based on common social factors that influence sexual and reproductive health outcomes. You can choose a few that are most appropriate, or add different ones, according to what you hope to achieve.

Changing diapers, giving the kids a bath, and feeding the kids are only the mothers' responsibility.

Notes and probing questions for facilitator

Society expects women to address the physical, emotional and social well being of other people, especially their husbands and children, but men are not. Why? Is it because men are physically unable to bathe or feed children? It is because this work is primarily unpaid? Are women more inherently capable than men? Do you know any examples of people who don't fit that expectation?

People who agreed with this statement mentioned:

Men are supposed to do the "technical stuff" around the home. Women are supposed to look after the kids.

People who disagreed with this statement said:

I notice my sister is obliged to work more. My family is patriarchal. It is difficult for me to understand and accept the difference. It is simply like that.

It is a stereotype, from patriarchal society. There are no male and female chores, only those I like and those I don't like.

Women's work is not so valued, nor appreciated in society.

Recent social and economic changes mean that more women nowadays are working outside the home and earning a salary. But it is also women who continue to carry out housework. As such, women get up earlier and go to bed later. Women's responsibilities in the home mean they have less time for rest or leisure.

A man should have the final word about decisions in his home.

Notes and probing questions for facilitator

Should a woman have any input about decisions in the home? What would happen if men and women were equal partners in decision-making?

People who agreed with this statement mentioned:

The man should be head of the house; a man and a woman cannot be on the same level.

I think it is positive that a man should stay the head of the family as long as he does not use violence.

People who disagreed with this statement said:

But how is total equity possible if one person is head of the family?

He shouldn't have big authority; they should be equal.

M.Prvuloviç/CARE

It is a woman's responsibility to avoid getting pregnant.

Notes and probing questions for facilitator

What are different ways to avoid an unintended pregnancy? Which ways are controlled by women? Which are controlled by men?

Why should a man be concerned about avoiding an unintended pregnancy? Why should a woman?

In your community, are there any social consequences for men who father children but don't take responsibility? What about for mothers who don't take responsibility?

People who agreed with this statement said:

Men expect women to take care of these things; it's a woman's responsibility.

People who disagreed with this statement said:

They are both involved; they both need to take responsibility.

An unmarried pregnant girl should be expelled from school.

Notes and probing questions for facilitator

Why do many schools decide to expel pregnant students?

Why are the boys who impregnate girls not expelled from school or punished in any way? What if the girl is pregnant as a result of rape or incest, or sexual abuse by a teacher? Does she deserve to be punished? Why or why not?

What might be the consequences on the girl's future if she is expelled from school? What might be the consequences for the girl's child?

A woman should choose whether or not to have sex, just the same as her husband can.

Notes and probing questions for facilitator

Do women have a right to say "no" to sex with their husbands? In many countries, this right is protected by national law.

Often it is expected that sexual activity is primarily for reproductive purposes for women, but men need to have sex in order to satisfy their sexual desires. Do you think women have sexual desire? Do you think society expects women to have desire, or not? Is that true for all women, or some women?

Participants who agreed with this statement said:

Both men and women are participating, and both have a right to say "yes" or "no."

Participants who disagreed with this statement said:

The husband has a right to make all decisions in the household.

Men have a right to sex with their wives.

A man needs other women, even if things with his wife are fine.

Notes and probing questions for facilitator

Very often we hear that men have a need to fulfill their desire. Do you think that men have more need for sex than women? Women are often taught how to discipline their desires and men's desires. Do you think men can discipline their own desires?

Participants who agreed with this statement mentioned:

It is his right to learn about sex and discharge his sperm, even if he is married or on business trips.

It is a personal choice.

Participants who disagreed with this statement said:

What about the rights of his wife? Does she have any rights to say anything about the risks that come along with this choice of his?

Sarah Kambou/ICRW

It's normal for men to have sex with other men.

Notes and probing questions for facilitator

Medical and social scientists tell us that homosexuality is not an illness. Simply put, some people feel sexual attraction to, or desire, sexual activity with persons of the same sex. It happens fairly often in all countries and cultures.

Some people feel it is wrong for religious reasons. There is some debate in most religious traditions about whether same-sex sex is immoral or morally neutral. There are liberal individuals and groups in Christianity, Islam and other religious traditions who are now writing that same-sex sex is normal and natural for some adults. Others from a more conservative tradition maintain that it is immoral.

Some participants who agreed with this statement mentioned:

Sex should only be between men and women, therefore same-sex sex is not a normal thing.

It is a kind of disease where a person has something wrong with their body.

Some participants who disagreed with this statement mentioned:

We know of perfectly normal, loving relationships that are between two men.

In the Vietnamese context it is considered abnormal, but it is a person's right to make the choice.

Some people get sexual pleasure from same-sex relationships.

It is normal to want to satisfy ourselves in different ways.

Some participants weren't sure:

Feels wrong… but is it?

I think people are homosexual because of a genetic abnormality, but I also believe it is socially normal.

STEP 3: Discussion

Initiate a discussion with the group using some or all of these questions as a starting point; ask additional probing questions as appropriate. Encourage debate within the group, and be ready to spend some time discussing the issues that arise.

- How did it feel to confront values that you do not share?
- What did you learn from this experience?
- How do you think that society's expectations influence our own health or decisions about health?
- Did you change your opinion about any of the issues?

STEP 4: Closing

Thank participants for their honesty, and their willingness to open their minds to different ways of thinking. Emphasize that values clarification is an ongoing process. It is normal to re-evaluate our attitudes as we grow and mature, and as we gather new knowledge and experiences.

Ask participants: How will this values clarification exercise contribute to your work? How will it contribute to your personal growth?

Notes to the Facilitator

It is important to maintain a non judgmental atmosphere during this exercise. These may be complicated, emotional issues, and some participants may react strongly. It is important to remember everyone brings their own personal perspective to the work of the group, and to respect people's personal opinions, without making anyone else feel like their opinions are worth less or more.

Tool #10: Program Principles Analysis

Objective:
- To help staff understand the relevance of CARE International's Programming Principles to gender and sexuality
- To help staff critically analyze their own reproductive health and HIV program approaches

Timeframe: preferably an entire day; if necessary, the exercise can be reduced to half a day by discussing some scales in more depth than others

Materials needed: photocopies of the Programming Principles handouts (all seven pages) and worksheet for each participant; flipchart paper, pens and markers

Ideal workspace: enough space for participants to see the flip charts and move about the room freely

Number of participants: 4-20. The exercise is carried out in smaller groups of up to 5 people each; each small group is asked to analyze where their own programs fall on the CI Programming Principles scale.

Introduction

Addressing the deeper social and cultural issues within traditional health projects can be discouraging, and many people are not sure how to start. As CARE staff members become more aware of the contextual issues affecting health, questions arise about how to take the work forward, or how projects would be different if social conditions were also addressed.

By putting CARE International's Programming Principles into concrete terms, this tool can help staff visualize how project interventions would change if contextual issues were addressed more or less fully. It defines a continuum of program approaches as another "lens" through which to view our work and measure progress.

One of the assumptions of this exercise is that we have the capacity to be self-critical, to acknowledge limitations of past strategies, and to see opportunities to move forward in the future.

STEP 1

Introduce the exercise by explaining the objectives, and how much time you expect it will take.

Distribute copies of the CARE International Programming Principles document (all seven pages).

Read through the six CARE International Programming Principles. Ask questions to make sure that everyone understands them.

Distribute copies of the CI Programming Principles worksheet (see page 93). Do one example as a large group to show people how to use the worksheet.

Instruct participants to discuss the extent to which their project or sector follows the CARE International Programming Principles. Give the groups 1-2 hours to discuss, and tell them that they will present their findings to the larger group.

When they have finished, ask each small group to present their findings to the larger group, including why they chose to position their project on the levels that they did.

Facilitate a group discussion about the exercise, asking:

- What do you think about the other groups' results?
- Do you have any comments on the process of the exercise? Did anything surprise you?
- How was this exercise useful in exploring the possible range of programming approaches to social justice related to gender and sexuality?
- What could we do to improve our programming approaches? What would help us make these changes? What might stop us from making these changes?
- What are your concerns or thoughts about these potential changes?

Notes to the Facilitator

If the group is bigger than 5 people, form smaller groups of about 4-5 people each. If possible, form the groups so that everyone in a group has a similar level of familiarity with a particular project. It is preferable to form small groups to discuss one project in depth, rather than trying to analyze several different projects.

The facilitator will preferably be a "semi-outsider" – someone who knows the group, knows about CARE's principles and rights-based approaches, but is not directly involved in the project, program or sector that is being analyzed. He or she knows how to lead a complex and long group discussion.

Doris Bartel/CARE

CARE International Programming Princples – Overview

Principle 1: Promote Empowerment

We stand in solidarity with poor and marginalized people, and support their efforts to take control of their own lives and fulfill their rights, responsibilities and aspirations. We ensure that key participants and organizations representing affected people are partners in the design, implementation, monitoring and evaluation of our programs.

Principle 2: Work with Partners

We work with others to maximize the impact of our programs, building alliances and partnerships with those who offer complementary approaches, are able to adopt effective programming approaches on a larger scale, and/or who have responsibility to fulfill rights and reduce poverty through policy change and enforcement.

Principle 3: Ensure Accountability and Promote Responsibility

We seek ways to be held accountable to poor and marginalized people whose rights are denied. We identify individuals and institutions that have an obligation toward poor and marginalized people, and support and encourage their efforts to fulfill their responsibilities.

Principle 4: Address Discrimination

In our programs and offices, we address discrimination and the denial of rights based on sex, race, nationality, ethnicity, class, religion, age, physical ability, caste, opinion or sexual orientation.

Principle 5: Promote the Non-Violent Resolution of Conflicts

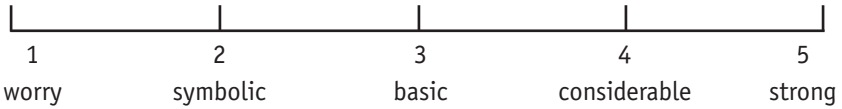
We promote just and non violent means for preventing and resolving conflicts at all levels, noting that such conflicts contribute to poverty and the denial of rights.

Principle 6: Seek Sustainable Results

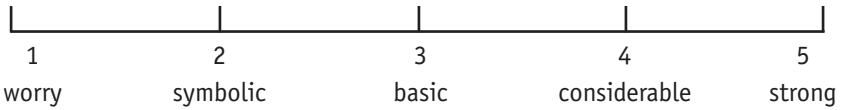
As we address underlying causes of poverty and discrimination, we develop and use approaches that ensure our programs result in lasting and fundamental improvements in the lives of the poor and marginalized with whom we work.

CI Programming Principles Worksheet

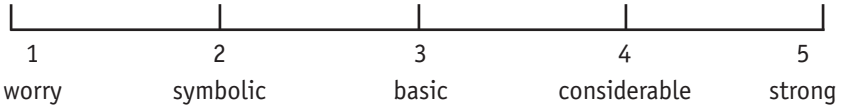
Principle 1: Promote Empowerment



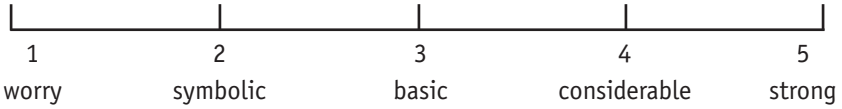
Principle 2: Work with Partners



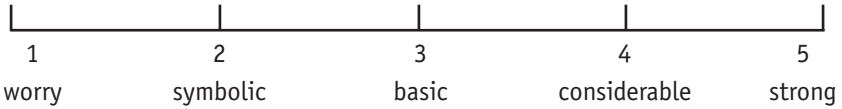
Principle 3: Ensure Accountability and Promote Responsibility



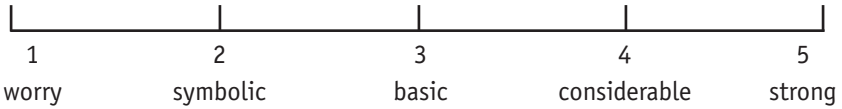
Principle 4: Address Discrimination



Principle 5: Promote the Non Violent Resolution of Conflicts



Principle 6: Seek Sustainable Results



CI Programming-Principles Scales: How Are We Doing?

Principle 1: Promote Empowerment: We stand in solidarity with poor and marginalized people, and support their efforts to take control of their own lives and fulfill their rights, responsibilities and aspirations. We ensure that key participants and organizations representing affected people are partners in the design, implementation, monitoring and evaluation of our programs.

Worry	Symbolic	Basic	Considerable	Strong
We know the people we serve are poor and marginalized. By delivering technically sound programs to them, we certainly help them. We are in solidarity, because we help them out. We let them know about our activities if they need to.	We are concerned about the condition of the poor and marginalized. Besides delivering the quality services they need, we often speak in general terms on their behalf to other stakeholders. We are in solidarity with the poor and marginalized; we help them where we can. We also ask others to do so. We inform them in general terms. On some operational issues we occasionally ask their advice.	We know that neither CARE nor the NGO world as a whole is going to end poverty by delivering services. Other stakeholders need to be pushed. Speaking on behalf of the poor and marginalized to other stakeholders, in terms that probably won't affect our own security nor our financial resources, is a function and responsibility of ours. Our core activity, however, remains delivering quality services. As professionals, we help. We are diplomats on their behalf when taking a position does not seem to have negative consequences for us. We ask for their opinion about our project and take that in to account as long as no serious change is required.	The poor and marginalized are our partners. Their concerns are ours. The way they perceive their own situation in terms of condition, position, causes and solutions is key for us. We discuss these and our own views, and try to develop a shared strategy to improve their conditions and position. We are transparent to them from the beginning and let them know which risks we don't want to take as an organization, as we accept the level of risk they want to take and the pace of change they seek. We walk the talk and defend their rights. When their rights are threatened by supporters of ours, we try to find a compromise. The project is theirs as well as ours. However, we are also accountable to donor requirements. Sometimes we might need to push something through.	The poor and marginalized are our partners. Their concerns are ours. Their struggle is ours as well. Social change doesn't come easy. On the basis of a profound understanding of our shared situation, we develop a vision and a strategy we will implement and adjust together as we move forward. In principle, we don't run away from commonly agreed-upon risks, because our presence decreases the risk for our partners. But we try to decrease the risks also by strengthening the public support for our case. We are in this together and stand by them even if this means opposing long term supporters of ours. This is their project as it is their lives. Once we have a principled engagement and we feel they respect it, we let their opinion dominate. If we disagree we tell them so, but that does not mean they should take that. We avoid donor relations that might compromise our independence.

CI Programming-Principles Scales: How Are We Doing?

Principle 2: Work with partners: We work with others to maximize the impact of our programs, building alliances and partnerships with those who offer complementary approaches, are able to adopt effective programming approaches on a larger scale, and/or who have responsibility to fulfill rights and reduce poverty through policy change and enforcement.

Worry	Symbolic	Basic	Considerable	Strong
The others are our colleagues but are also competitors. Obviously we won't do anything to make their work more difficult, but working together makes sense on special occasions. If everybody does a good job, all are served.	Partnership is a principle for us. It is referred to in our mission. We need to know what others do so that we can complement each other; duplicating work makes no sense.	We want to work with others to achieve things we cannot achieve on our own. Partnerships may not mean that others determine what we do. We need to decide fully about our parts and get credit for what we do. Others can win as well, but it can't be that another partner gets the prestige or funding instead of us. At least we need to break even: The other may score today if we can score tomorrow.	We believe in long-lasting relationships with other organizations with whom we share information and plans. Besides that, we develop a common agenda with our partners that relates to issues of interest to all. We dedicate significant resources to these partnerships. We are a loyal partner and aren't really concerned about the relative benefit that different partners get from the partnerships we are involved in. What counts is to move forward the common agenda that we adhere to.	We share and plan major issues with others, even if they won't be involved in the implementation. We also contribute to others' processes if we are invited. We are convinced we have to elaborate with partners on our common strategic goals that would contribute to the social change we envision. We want to be considered a partner of choice as we actively search to let the sun shine on all. The achievement of the strategic goal is most important. In the long term, the others know that they can count on us. We oblige ourselves to be creative in our search for shared strategies to achieve the important results we cannot reach alone. For example, we can plan an advocacy strategy with another organization in which one of us takes a hard stance and the other a softer one; both parties may consider the softer stance achievable and relevant, but it never could be considered as an acceptable compromise if the radical position did not exist.

CI Programming-Principles Scales: How Are We Doing?

Principle 3: Ensure Accountability and Promote Responsibility: We seek ways to be held accountable to poor and marginalized people whose rights are denied. We identify individuals and institutions that have an obligation toward poor and marginalized people, and support and encourage their efforts to fulfill their responsibilities.

Worry	Symbolic	Basic	Considerable	Strong
We do what we can to alleviate the suffering of the poor and marginalized with the resources we can get. What others do is their business. Who are we, or who are the poor, to hold others accountable?	We are convinced development would go much faster if other stakeholders would contribute more. We speak in general terms about the need for more generosity from the North and more goodwill from the South. We formulate a general demand, but don't talk in terms of responsibilities, because we aren't a political organization.	Sometimes, we speak out and challenge certain actors to improve the condition of the poor. We make a stand when the time is ripe for it and nobody will deny we're right. In the meantime we join coalitions that strive for a smooth change in benefit of the poor.	We try to be as principled as we can by defining actors and responsibilities. To the extent we have reason to believe we can influence them somehow and the risks involved for us aren't too big, we make claims. We are principled diplomats for pro-rights policies. We try to get our message across even to actors who prefer not to hear the message. However we do so smoothly in order not to burn any bridges.	We have principles and we abide by them, even if others might not be convinced of what we say or oppose it because what we claim is against their interest. We develop a broader vision than just an issue-by-issue one. It's a role for NGOs like CARE to make things possible that don't seem possible yet. We make the time ripe if needed. We are not afraid of losing a major donor's support because of that. Our principles don't allow us to shut up and nod to someone just because we want his money to do something that does not affect the root of the problem.

CI Programming-Principles Scales: How Are We Doing?

Principle 4: Address Discrimination: In our programs and offices we address discrimination and the denial of rights based on sex, race, nationality, ethnicity, class, religion, age, physical ability, caste, opinion or sexual orientation.

Worry	Symbolic	Basic	Considerable	Strong
We work for the poor and the marginalized and improve their condition; we work against discrimination. We keep it implicit.	The organization has decided that opposing discrimination is a principle for us, so we must try to keep it in mind in what we say and do internally as well as externally. It's a principle we write in our vision and we hang a nice poster referring to it on the wall. We keep away from known discriminators.	Minorities are often doubly discriminated against. We develop general guidelines to look at this, and specific people in the organization question our own systems and practices regularly. We all keep an eye on it and have our special watchdogs. We avoid partner organizations that seem to practice discrimination.	When we design programs, we make specific and precise analysis in terms of discrimination. Our programs pay special attention to those groups and try to improve their condition as far as our program has the flexibility to do so. We try to set a good example and not discriminate. It's part of good programming for all. It's not optional; everybody is trained in it. We speak up diplomatically to other actors that seem to discriminate.	We not only analyze the existing patterns of discrimination, we also try to find out where this discrimination is rooted and to fight these factors. We want to change the position of the discriminated. We apply affirmative action and advocate to include the work against discrimination in the project, even when donors are reluctant to do so. We evaluate our programs and our personal performance in terms of what we do to fight discrimination. We do not partner with any organizations that discriminate without openly confronting and seeking to redress it.

CI Programming-Principles Scales: How Are We Doing?

Principle 5: Promote the non-violent resolution of conflicts: We promote just and non-violent means for preventing and resolving conflicts at all levels, noting that such conflicts contribute to poverty and the denial of rights.

Worry	Symbolic	Basic	Considerable	Strong
We apply technical solutions to the problems we see; we promote non-violence. We believe that improving the conditions of the poor contributes to the nonviolent solution of major conflicts. We are neutral. If to do our job we need to be blind and deaf, we do so. Isn't it obvious we are non-violent?	Non-violence is a principle for us. However, when we see violence against the poor, we denounce it in general terms. We take care not to become part of their conflict. It's a principle we apply in our own work and one which we casually promote to others.	We analyze a situation with regard to the poor and the alternatives to improve it with them; we only consider peaceful solutions. We justify that stand to them, and give examples of how this has worked in other contexts. Where violence impedes development, we consider taking some action. We organize conflict management courses for staff who might need it.	As we analyze a situation, we denounce diplomatically the structural violence and other types of violence we encounter. We oppose the use of violence ourselves, and request that no other stakeholders use it. Because we deal with lots of conflicts, we are highly trained in conflict prevention and peaceful conflict resolution.	We oppose all violence. In particular, we publicly denounce violence against the poor and marginalized, and we point out their lack of democratic means. Particularly violence against the poor and marginalized, we denounce publicly. We also indicate how little democratic means the vulnerable have. We justify our stand on non-violence, but actions of civil disobedience are options. Our action demonstrates also that non-violent action can be a very powerful and active form of protest. We try to be creative in finding additional, powerful (but peaceful) action strategies. We always respond to violence committed to us or to people we work with, but we do so in a non-violent way. If that increases the danger to us or to them, we increase security measures and develop alternative strategies for which the entire organization pays the cost.

CI Programming-Principles Scales: How Are We Doing?

Principle 6: Seek Sustainable Results: As we address underlying causes of poverty and discrimination, we develop and use approaches that ensure our programs result in lasting and fundamental improvements in the lives of the poor and marginalized with whom we work.

Worry	Symbolic	Basic	Considerable	Strong
At most we can consider structural injustices as contextual factors. Being realistic, we assume they will continue to be part of the context in which we work. Therefore we can put them in the "assumptions" column of our logical frameworks. We work for the poor and marginalized. They lack skills and expertise. By helping them with our technical knowledge, their conditions will improve and we will see immediate results.	We certainly need to know what's behind the problems we try to solve, but we focus on what we can do and what we are good at, and that's a technical issue. As far as the analysis helps us in directing our technical solution, we take that information into account. We are well-informed of deeper contextual issues at meetings, because we have read textbooks and recent articles. We work for the poor and marginalized as professionally as we can. But somehow we know that even an expert sometimes should listen to the one she helps, like a doctor listens to her patient.	In cases where the root of the problem is clear to almost everyone and there is support to go beyond the troubleshooting approach, we address the deeper causes, particularly if these are located at micro-level. We want to understand the world in which we work. We also want to change it as long as working on the causes does not imply a funding or security risk. We are working for the benefit of the poor, so we consult them throughout the process – from the diagnosis to the implementation to the evaluation. To the extent that it is possible, we share responsibilities with them so that they can learn.	In some cases we dig deeper and make a strong technical case to address a root cause. We promote strategies that address root causes of interest to all stakeholders involved. The poor and marginalized we work with are part of the decision-making from start to finish. To the extent their opinion sounds technically correct and stays in line with donor requirements, we go along with it. We try to hand over different types of responsibilities gradually. We build the capacity of marginalized groups with the conviction that they can influence factors that affect their lives.	It's our job to stand in solidarity with those who speak out about social, structural and human-condition injustice, even if some don't want to see or hear it. We make a technically strong case, but aren't afraid of making a stand on principle. Along the principle that we don't back off just because of intimidation, we define strategies to resist intimidation and imminent danger by raising security or alternative strategies. If that is needed, CARE as a whole shares the cost. Leadership and decision-making is made at the local level by networks of marginalized groups working in solidarity. CARE is a partner.

Tool #11: Reflective Practice

Introduction

Reflective Practice (RP) is the process of thinking about our learning. It can be a philosophy of inquisitive learning that we incorporate into our daily lives, or it can be a structured approach that a team embeds in its work. Either way, Reflective Practice is a process of periodic reflection, discussion and documentation designed to develop critical thinking skills and enhance learning.

For purposes of Social Analysis and Action, RP is presented as a group dialogue process with the ultimate goal of improving the responsiveness and effectiveness of our interventions.

Objectives:
- To think critically as a group about how a project is progressing
- To brainstorm changes to the project that may be necessary

Timeframe: periodic meetings can last from an hour to a full day; half-day meetings each quarter are recommended

Materials needed: flipchart paper, markers, tape

Ideal workspace: enough space for all participants to gather comfortably

Number of participants: 5-20

STEP 1: Posing Questions

Together with a team of key stakeholders, develop questions to help the team explore what seems to be occurring within a program. Some basic questions are listed below to get you started. Over time you will develop questions tailored to your own programs.

- What are we **intending to accomplish**? What **changes are we trying to promote** through our processes and actions?
- According to our observations and the data that we are collecting in the course of our work, **what is actually happening**? How are the processes unfolding?
- What are the **outcomes**? Are they planned or unplanned?
- What has **changed in our operating environment** since we began?
- What do we **know now** that we did not understand before?

STEP 2: Gathering Data

As a team, identify who is in a position to provide answers to the questions you have posed. Data can be collected through observation, key informant interviews and/or focus group discussions. Be sure to talk with a range of people to bring in a diversity of perspectives.

In preparation for the stakeholder meeting (Step 3), summarize the data that you have collected so that you can present it to the other stakeholders.

Jaime Stewart/CARE

STEP 3: Stakeholder Meeting

Openness, a spirit of inquiry and a desire to learn should characterize the atmosphere of stakeholder meetings. Ideally, the number of participants should be 20 or less, so that meaningful discussion can take place in a relaxed setting.

All participants in stakeholder meetings should be on an even playing field; this is not intended to be a situation where some people (CARE staff, for example) ask the questions and others (such as partners, participants or other stakeholders) answer. The discussions should facilitate mutual exploration and learning.

Before the meeting begins, identify members of the group to take on the roles of **reporter** (to record major points and conclusions on flipchart pages) and **ethnographer** (to take note of the richness of the conversation, including major points of dissention and agreement; "aha" moments; body language; individual and group behavior during exploration of difficult issues; breakthroughs; and development of agreement and consensus).

Facilitate a discussion that leads participants through the set of initial questions that were posed in Step 1.

Then, work through the additional questions below (or a similar set of questions that you develop based on your local programs and context), which are designed to help participants to analyze information, develop some conclusions and agree upon recommendations for future action.

- In our assessment of processes and immediate outcomes, **what have we learned**?
- **Why** are things happening in the manner that we've observed?
- What is **supporting** us in achieving our intended outcomes?
- What is **hindering** us from achieving our intended outcomes?

Jaime Stewart/CARE

- Given these changes, observations and learning, **what modifications do we suggest** in intentions and strategies (e.g., outputs and activities)?

- What are the **specific, actionable recommendations**[1] that the majority of stakeholders agree on?

[1] Whiffen, Paul (2000) "Techniques for Capturing Learning in Tearfund," Tearfund, London, page 2

STEP 4: Documenting Conclusions and Shifts in Strategy

The fourth step in the reflective practice process is to synthesize and document major conclusions, observations and strategy revisions that arose during the discussion. Keep simple but useful records to ensure that learning and plans generated from the discussion are not lost.

It is important that the following major outputs are documented in a visible manner during the stakeholder meeting:

- Synthesized answers to initial questions posed: What were we intending and what is actually happening?
- Areas of agreement and areas of disagreement among meeting participants
- Processes and actions that seem to be going well
- Changes in operating environment and/or new understanding of issues, occurrences or dynamics in operating environment
- Key lessons learned in relation to the questions posed
- The reasons behind the current situation – i.e., supporting and hindering factors
- Proposed modifications in intervention strategies and processes supported through the project
- Specific, actionable recommendations

At the conclusion of the meeting, review the major outputs with participants to ensure that what has been recorded during the meeting is an accurate reflection of what was said and agreed to. Make sure that responsibility is delegated for making, communicating and implementing any agreed-upon modifications to project strategy. As a group, agree on a date for the next RP stakeholder meeting.

In the first week after the meeting, the meeting reporter should compile the output for circulation among all participants and to other key stakeholders.

Notes to the Facilitator

Stakeholders in the RP process will vary according to what you are seeking to learn; stakeholders could include project staff, senior country office management, government counterparts, local partners and/or project participants.

A skilled facilitator is essential to successful RP. You should have an in depth knowledge of the issues you are exploring, as well as extremely well-developed facilitation and people skills. As facilitator you should:

- Always help the group to look for what can be learned from the things that are working and the things that are not working;
- Never criticize or make anyone out to be wrong;
- Ensure that hierarchy does not prevail in the discussion (everyone has an equal right to learn from what is being said); and
- Guard against personalizing the discussion.

At the heart of reflective practice is a positive attitude toward questioning and learning. To encourage critical thinking and mutual learning, work to establish a spirit of openness, curiosity and non judgmental learning from the beginning. It is up to you and your country office leadership to set these standards and model this behavior. Examples of these standards include the following:

- Openness – in relation to both offering and receiving information.
- Everyone's input is equally valued; "leaders" and "led" are on equal footing.
- RP is undertaken in the cause of learning – and NOT for the purpose of assigning blame or evaluating the efforts of individuals or groups.
- Questioning is done with an appreciative attitude – looking for what is working, rather than starting with a focus on the "problems."
- Lively participation by all participants is encouraged.
- Confidentiality is respected – "who said what" will not go beyond the individuals present.
- Shared commitment to work toward consensus, yet willingness to acknowledge and respect different positions and move on when consensus cannot be reached.
- Embrace error! – there is great value in acknowledging freely what has NOT worked, articulating the lessons that are being learned and moving on from there.
- Everyone has a piece of the truth – by sharing viewpoints, information and insights, all present can enhance the depth and completeness of their understanding.

The concepts, ideas and exercises in this tool draw heavily on the following resources:

Caldwell, Richard (2002). *Project Design Handbook*, CARE USA, Atlanta.

Senge, Peter, et al (1994). *The Fifth Discipline Fieldbook: Strategies and Tools for Building a Learning Organization*. Currency Books, Doubleday, New York, NY USA.

Whiffen, Paul (2000). "Techniques for Capturing Learning in Tearfund," Tearfund, London.

Tool #12: Most Significant Change

Introduction

Sometimes changes happen in a project area that no one expected. They might be changes for the better, or perhaps changes for the worse. Unless you have a way of monitoring for these unexpected things, you may not be able to notice them, or be able to change your intervention strategies to deal with them.

One way to set up a routine monitoring for important changes is to use a "reflective practice" methodology with project staff, in which staff meet on a regular basis and think through their own insights into what is happening, and why, and agree on next steps (see general guidelines for Reflective Practice in Tool #11, page 107). Many CARE projects are starting to use and see the positive effects of reflective practice.

Most Significant Change[1] (MSC) was developed as a story-based method of monitoring that uses a basic question: "What is the most significant change that has happened since the project started?" It relies on active participation and critical thinking on behalf of team members. The facilitator helps the team collect, process and review data as evidence of what is happening. Then the facilitator guides the team in a reflection of why it is happening, and what the implications are for next steps.

Objectives:
- To reflect with colleagues and peers on what changes have happened over the course of a period of time
- To evaluate why the changes happened
- To analyze implications for future intervention strategies

Timeframe: It is helpful to start with an initial training workshop of 1-2 days, so that staff understand reflective practice methodology in general and the MSC technique in particular. After that, it usually takes about 2-3 hours each month to collect and document stories. A meeting to select the stories, analyze them and plan next steps takes about 4-8 hours. This is repeated approximately every 3-6 months.

Materials needed: an agreed-upon set of basic questions as a protocol

Ideal workspace: enough space for all participants to gather comfortably

Number of participants: 5-10

[1] Developed by Rick Davies and Jess Dart, and as documented in Davies, R. and Dart, J. (2004). The Most Significant Change (MSC) Technique: A Guide to Its Use. The complete Guide to MSC can be found at: www.mande.co.uk/docs/MSCGuide.pdf

Overview

The simplest way to explain the MSC process is to say that members of a work team ask a variety of stakeholders a question:

> *"Looking back over the last month (or other specific time frame), what do you think was the most significant change in [a particular domain of the project]?"*

Once a number of narratives or stories are collected about this and documented on paper, these collected stories are shared with the entire team and their supervisors, posing a similar question:

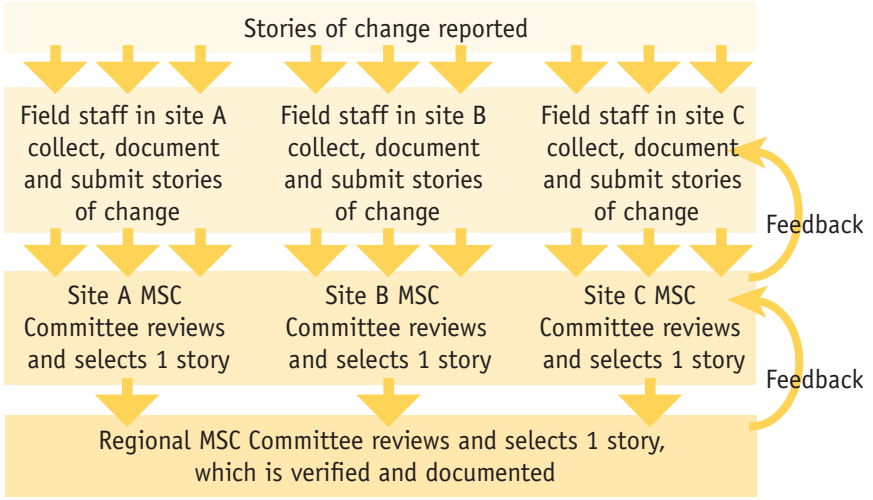
> *"From among all these significant changes, what do you think was the most significant change of all, and why?"*

The collection of the initial stories is important, and the sifting and filtering of the stories through a process of review and reflection is also an important step. As stories are selected from the many collected, participants discuss and identify why some stories are more significant to them than others. The process of discussion and argument helps bring to the surface the selection criteria and values behind participants' choices, as well as their assumptions about what has taken place in the story.

Ariel Frisancho Arroyo/CARE

There are many different ways of structuring selection processes. One way is to make use of existing organizational structures, so the values of people within different levels of the organization are made more visible and open to discussion, and change. For example, as a second filtering process, selected stories from a number of work teams can be sent to another set of supervisors, on the project or country program, for a second set of review and analysis, ensuring that various levels of supervisors in the organization are participating in the story selection criteria and final section. Each time stories are prioritized and selected, feedback should be channeled to all interested stakeholders. The final selection of "significant change" stories is usually verified, and then documented. This example process is outlined in the figure below.

MSC Collection and Selection Process



It is important to note that the story that is selected as the Most Significant Change at the final level of this selection process is not the only significant story out of all the MSC stories. It is however, the story that has the *widest* significance, being seen as important by a *larger number of people*. At the same time, all the stories that were initially documented still have their local significance. Similarly, a story may be featured in a local newspaper but not in a national newspaper. Alternatively, a local story may be seen as so important by others that it appears in national newspapers.

STEP 1: Collecting the Stories

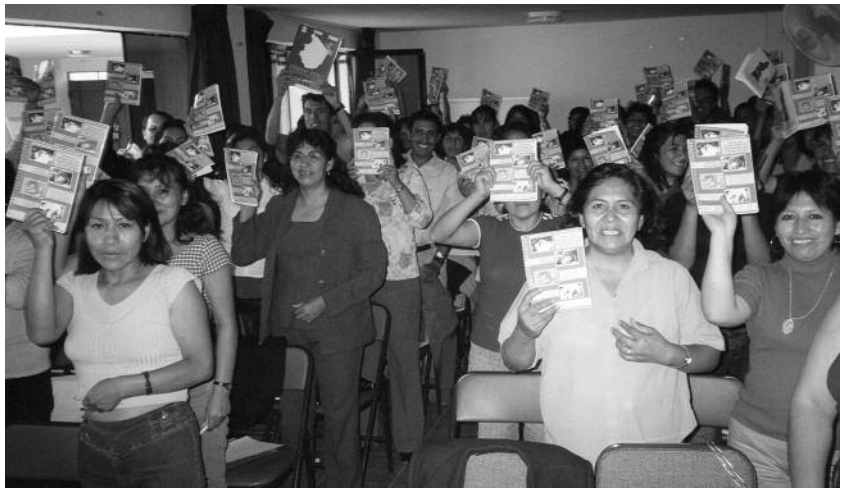
After training staff on the methodology, ask staff to collect stories from stakeholders using the following question to guide them:

> *"Looking back over the last month (or other specific time frame), what do you think was the most significant change in [some particular domain of the project]?"*

You will have to decide which particular question you want to ask, including which domain on which to focus, and the specific time frame. The particular domain might be one of the objectives of the project, or something more general, such as: "the quality of people's lives in the community." It may be only about changes caused by the project, or about changes arising from any cause. A clear choice needs to be made and communicated to participants about which of these is of concern.

Staff can collect stories using a number of different techniques, including: (a) writing down unsolicited stories that they have heard in their case work, or (b) by nominating staff to interview project participants using this question, or (c) gathering a group of participants together and conducting a focus group using this question guide.

Information to be documented should include: (1) information about who collected the story, and when the events occurred; (2) description of the story



CARE

itself (the story should be documented as told, and include factual, descriptive information about what happened, where and when, and with whom); (3) significance (to the story teller) of what happened in the story, such as why the person felt it was important to share.

Sometimes participants may not immediately understand the question being asked. If so, it is best to start with more general questions, asking about the types of changes that have taken place in a specific time period. Then, after it becomes evident that there have been many, help the participant to focus in on the change they think was most significant of all. Resist the temptation to provide a highly structured set of questions, because this will destroy any storyline, and the results will end up looking like another report.

Including a question about negative changes helps keep the project honest about both positive and negative changes that may be happening.

Note on ethics of collecting stories: Please use standard consent procedures prior to asking people to share stories, including informing participants why you are asking the questions, what will happen to the information, reassurance that the information will be kept confidential (no names will be used) and requesting consent to continue with the process.

STEP 2: Selecting the Stories

Set up a selection team

It's helpful to select a small committee to review the stories and make the selections. Who you choose to involve on this selection committee depends on whose voice and values you want to hear about. It could include a variety of stakeholder groups including project participants, partners, government representatives or peers. Past experience shows that it works well if this group includes people who did not collect the stories.

Selection process

All the stories are documented and shared among the selection committee. Everyone reads the stories and then sits down to discuss them. If several "domains" are being analyzed (for example, if stories were collected about several different project objectives), then the first step is to sort the stories into domain groups. In taking one domain group at a time, group members discuss their opinions about which MSC story is most significant and why, and decide together which story represents the most significant change of all. Group members also need to articulate and document why they made the choice that they did.

Group members can decide how to come to a conclusion about their choice. They can use a simple vote (either show of hands, or secret ballot), with majority ruling, or they can score each story on certain criteria and add up the points, or a combination of the two. The advantage to asking participants to score the stories ahead of time is that it helps participants to focus on selection criteria as they are reading the stories, and come to the meeting prepared. Regardless of the process used, there must be discussion and debate, not simply the counting of votes or ratings. These tools should aid the process of discussion, not replace it

With a larger group, or an inexperienced group, it can help to have an outsider who is an expert facilitator to ensure that the process moves along.

Document the results of the selection process

Assign someone the responsibility of documenting the process of selection, including the discussion of how and why the story was selected; this should be documented in a short paragraph. Ask them to include all the selection criteria, if more than one was used. This should be attached to the story.

Save the stories that were filtered out; these may be valuable for content analysis at a later stage. It can often be important to identify the relative frequency of different types of changes reported.

STEP 3: Implications for Future Programming

If an MSC story is significant it should have consequences, which may have already played out, or are yet to be seen. When an MSC story has been selected from among many others, there should be some identifiable implications for what the participants (in the selection process) should do next, either to promote or prevent this type of change. Facilitate a discussion about what the implications for this story are for the project. How should the project interventions be modified to respond to the positive or negative things happening? Document these recommendations in the form of practical next steps.

STEP 4: Feedback on the Selection Process and Implications

Next, share the documentation of the final story chosen and the process of how it was chosen, and why, as well as implications for project interventions, with those who collected the stories. This can be done verbally in a meeting, or if the group is widely dispersed, through newsletters or e-mail. Some organizations are now thinking of using video feedback, showing the highlights of the selection discussion to those who sent in their MSC stories.

You can also share feedback with the broader community in which the project is being implemented, either through community forums or newsletters.

Optional Additional Steps

Verify stories through qualitative data collection in the field with additional participants, not only to make sure the facts are correct, but also to describe this most significant MSC story in much more detail, producing something that could subsequently be used for training or reporting purposes.

Analyze the content of all the stories, not just those that "survive" a multi-level selection process. Events in the stories can be coded as different types of events, such as "credit repayment problems" or "gender discrimination," and the frequency of those events counted across all the collected MSC stories.

Notes to the Facilitator

The guidelines presented here are designed for work teams of CARE staff and partners to use on a regular basis as part of a routine reflective practice cycle. It is especially useful with project participants and field-level staff, but can also include senior country office management, government counterparts and local partners.

Most qualitative research methodologies use an analytical process that focuses on summarizing common themes. This is very legitimate, but different from the processes outlined here in the Most Significant Change methodology. In MSC, the selection process is critical, because it helps you focus on the "exceptional" rather than the "average" story. By selecting the exceptional story – the most significant – you focus on one of the most important things that will help you improve your program. If it is a thing that is contributing to success, you will want to find ways to enhance it. If it is a significant problem, you will want to address it.

The following is an example that shows the difference between MSC and other qualitative analysis processes, and its implications for learning and improvement:

> *Recently, a staff member of an NGO visited all the NGO sub-offices to look at their financial management procedures. Overall, it was found that most offices were doing the right thing (this is summary by inclusion, i.e., finding common themes) but there was one office where there was evidence of fraud. This was the MSC that was noted. Reporting this MSC had major consequences, both locally and further afield. It led to the revision of accounting procedures in the NGO, in all their offices, in order to prevent any other incidents of the same kind in other offices.*

It's true that someone could say, "But this event is unrepresentative of what is going on in our NGO." That statement would have been a correct generalization, and it could have led to inaction. But by focusing on the MSC there was some action, which may have helped keep that isolated observation from becoming a correct generalization in the future.

It is legitimate to do an "additive" analysis that is more common to qualitative methods, which would be a report focused on common themes of sound financial systems. This, however, has fewer implications for program improvement.

Why use "summarization by selection" in addition to "summarization by inclusion"? Because it helps you focus on the exceptional, which will have implications for actions that will improve the program.

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