



ENABLING CHANGE FOR WOMEN'S  
REPRODUCTIVE HEALTH



# IGNITING CHANGE!

*Accelerating Collective Action  
for Reproductive Health and Safe Motherhood*

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A Joint Thematic Paper of the ENABLE Project and The  
Maternal and Neonatal Health Program

August 2003



This publication was made possible through support provided by the Bureau for Global Health, U.S. Agency for International Development under the terms of Cooperative Agreement Numbers HRN-A-00-98-00009-00 and HRN-A-00-98-00043-00. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.

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## ACKNOWLEDGMENTS

This publication was made possible through generous support from the United States Agency for International Development (USAID). The Enabling Change for Women's Reproductive Health (ENABLE) Project and the Maternal and Neonatal Health (MNH) Program are grateful to USAID for making it possible to build, strengthen and document the social mobilization approach over the past ten years.

Thousands of champions for change have contributed to the ENABLE and M NH Program social mobilization efforts described in this paper. We want to thank all of the organizations and governments who have come together through social mobilization activities to create the social change necessary to improve the health of women around the world.

Special thanks should go to Premila Bartlett for providing research and a draft paper that contributed to the preparation of this paper. We are deeply indebted to Dr. Arzu Rana Deuba, Honorary Chair of the Nepal Safe Motherhood Network, who in 1996 ignited the flame for safe motherhood in Nepal and has since become a champion of safe motherhood globally. We continue to draw inspiration from Arzu and from the growing number of new champions for the cause as we expand to a global safe motherhood movement. Indu Kapoor, Executive Director of Chetna in Ahmedabad, India, shared her perceptions of the strengths, achievements and challenges facing the White Ribbon Alliance in India and the continued need for supportive and unbiased leadership dedicated to the cause of safe motherhood.

We would also like to give special acknowledgment and thanks to the following people who all contributed ideas, writing and inspiration: Dr. Ava Shrestha, Deepak Bajracharya, Angela Nash-Mercado, Judith Robb-McCord, Aparajita Gogoi, Cynthia Green, Annie LaTour, Meredith Miller Vostrejs, Christine Preston, Sri Kusyuniati, Luthfi Hasan, Donna Vivio, Sandra Crump, and Dr. Abdullah Cholil.

This was truly a group effort!

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August 2003

## ABBREVIATIONS

BCI.....	Behavior Change Interventions
BP/CR .....	Birth Preparedness and Complication Readiness
CEDPA.....	Centre for Development and Population Activities
COGES .....	Community Advisory Group
CORE.....	Child Survival Collaboration and Resource Group
DHS.....	Demographic and Health Survey
EmOC .....	Emergency Obstetric Care
ENABLE.....	Enabling Change for Women's Reproductive Health
EPI.....	Expanded Program on Immunization
FP .....	Family Planning
HIV/AIDS .....	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IAG.....	Interagency Working Group for Safe Motherhood
IEC.....	Information, Education, Communication
IFPS.....	Cooperating Agency for the Innovations in Family Planning Services Project
JHU/CCP .....	Johns Hopkins University/Center for Communication Programs
MAQ .....	Maximizing Access and Quality
M&E .....	Monitoring and Evaluation
MMR .....	Maternal Mortality Rate
MNH .....	Maternal and Neonatal Health Program
NGO.....	Non-Governmental Organization
NRCS.....	Nepal Red Cross Society
PQI .....	Performance Quality Improvement
RH.....	Reproductive Health
SIFPSA .....	State Innovations in Family Planning Services Agency
SMN .....	Safe Motherhood Network
STI.....	Sexually Transmitted Infection
TBA .....	Traditional Birth Attendant
UNFPA.....	United Nations Population Fund
UNICEF .....	United Nations Children's Fund
USAID .....	United States Agency for International Development
WHO .....	World Health Organization
WRA .....	White Ribbon Alliance
WRAI.....	White Ribbon Alliance India
ZWRASM.....	Zambia White Ribbon Alliance for Safe Motherhood

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**Social mobilization involves planned actions and processes to reach, influence, and involve all relevant segments of society from the national to the community level, in order to create an enabling environment and effect positive behavior and social change.**

## I. INTRODUCTION

For more than 25 years, health experts have known what it takes to save women's lives during childbirth, yet an estimated 500,000 to 600,000 women worldwide die from pregnancy and childbirth complications every year. Most childbirth complications cannot be predicted, and therefore, pregnant women and their families need to know what to do when an obstetric emergency occurs. Key interventions focus on reducing the three delays that contribute to delivery-related deaths – delays in deciding to seek care, reaching timely care, and receiving care (Thaddeus and Maine, 1994).

The Safe Motherhood Conference held in Nairobi in 1987 led to a partnership of international and national agencies committed to improving maternal health and maternal death and disability. At global United Nations meetings since then, the world's governments have pledged themselves to ensuring universal access to maternal and emergency obstetric care and to establishing or strengthening integrated safe motherhood programs. Much progress has been made: many countries adopted policies, donors committed funds, and communities enacted systems towards improving maternal health. Yet only a few countries have made the long-term commitments and investments required to ensure that women have access to safe, affordable, high-quality obstetric care.

To truly ensure safe childbirth for women around the world, broad-scale changes are needed throughout the various levels of society. Communities must pressure local and national leaders to put the necessary infrastructure in place to ensure that women give birth safely. Health systems need to have trained staff and facilities that can provide maternity care and handle obstetric emergencies. Political leaders must allocate sufficient resources to support safe motherhood programs. A joint 1999 WHO/UNFPA/UNICEF/World Bank statement on safe motherhood said:

*“The long-term commitment of politicians, planners and decision-makers to Safe Motherhood Programmes depends on popular support. Input from a wide range of groups and individuals is therefore essential, including community and religious leaders, women’s groups, youth groups, other local associations and health care professionals.”*

During the past five years, two global USAID-funded initiatives – The Enabling Change for Women’s Reproductive Health (ENABLE) Project and The Maternal and Neonatal Health (MNH) Program – have applied social mobilization to the field of reproductive health in order to accelerate change and have developed a specific model for its application. This paper covers the definition, theoretical basis and historical context of social mobilization with concrete examples of how the two programs applied the methodology to achieve programmatic objectives in reproductive health and safe motherhood. Country examples show how social mobilization resulted in forged alliances that have helped to increase awareness and secure political commitment, improve information equity, facilitate collaborative focused actions, and adopt evidenced-based practices.

The basis of the ENABLE/MNH Program social mobilization approach is the recognition that communication through dialogue and partnerships between multiple stakeholders is necessary to effect enduring change. By building on the strengths of a diverse network of organizations and donors, a strong base of power can be built that involves partnerships that seek solutions collectively. In Nepal the term “partnering pressure groups” was coined to describe the Safe Motherhood Network, which includes donors, government, NGOs, and community groups in its membership. The social mobilization model initiated in Nepal has been used by the MNH Program and the ENABLE Project for safe motherhood, but it can be adapted for other health issues, including family planning, HIV/AIDS prevention, and girls education.

**Social mobilization is a multi-level, dynamic approach that can be initiated either top-down or bottom-up. Community is perceived in its broadest sense to include all those who have a role and responsibility in effecting change. As information is made available and understandable to both experts and lay people, broad ownership and popular support are created.**

## II. THEORETICAL AND PROGRAMMATIC ANTECEDENTS

Social mobilization theories and applications are drawn from many disciplines, including community organizing, community building, social change theory, community participation, communication strategies, health education and promotion, social network theory, community mobilization, and behavior change theory. Some of the major theoretical antecedents of social mobilization are:

- Paulo Freire’s Conscientization Theory espouses the development of critical awareness through group discussion, experiential learning, and reflection/analysis (Freire 1970).
- Albert Bandura’s Efficacy Theory explains how individuals move from intent to action through a combination of collective efficacy (groups that are cohesive and believe they can act) and self-efficacy (perception of one’s capabilities formed through experience, observation, social persuasion, and emotional states) (Bandura 1995).
- Everett Rogers and D. Lawrence Kincaid’s Communication Theory stresses mutual understanding and convergence within communication networks for health promotion rather than an individual approach (Figueroa et al. 2002).
- Barbara Israel’s Social Network Theory is based on strengthening networks as a way of enhancing a community’s capacity to achieve its primary goals, such as empowerment (gaining control over decision-making) and community competence (joining in cooperative problem-solving strategies) (Israel 1985).

Social mobilization as an approach evolved out of UNICEF’s initiatives in the early 1980s to promote low-cost child survival interventions. UNICEF faced a major logistical challenge when organizing communities throughout each country to encourage mothers and other caregivers to bring children for immunizations and growth monitoring, adopt optimal breastfeeding practices, and treat diarrhea with oral rehydration solutions. Program managers knew that they could save many children’s lives if they could persuade decision makers at multiple levels

throughout the country to take the necessary steps to implement child survival interventions. They realized that they had to adopt a new approach that would go beyond their previous efforts that focused largely on individual behavior change.

Accordingly, UNICEF adopted a multi-pronged approach that encompassed communication through dialogue at multiple levels and among multiple audiences. It sought to broaden public support for child survival actions through advocacy to policymakers and other leaders. UNICEF also sought to form strategic alliances with national and local agencies in order to expand support for child survival programs and mobilize resources that could be applied to these programs. Social mobilization encompassed all of these components—behavior change communication, advocacy, alliance building, and mobilization of resources (McKee 1992).

For social mobilization to be effective and to build this base of popular support, communication needs to be a process of dialogue, information sharing, mutual understanding, and collective action. Standardized messages are used to promote a dialogue within the community as a whole. This dialogue is an essential part of building critical thinking skills (Aubel 2001).

Neil McKee (1992) lists five main approaches to mobilizing human and financial resources: (1) political mobilization, (2) government mobilization, (3) community mobilization, (4) corporate mobilization, and (5) beneficiary mobilization. Social mobilization uses community events to attract the attention of policy makers, community members, and media representatives and motivate them to take action on a specific issue such as immunization, literacy, or family planning. Social mobilization amplifies advocacy activities, strengthens communication, and allows many more societal partners to participate in the program.

Champions for change are concerned with building consensus and educating people to energize and empower them to take focused action. They share information and galvanize many stakeholders around an issue. The stakeholders then agree on a goal, develop key themes and messages, and exert political pressure for policy changes and increased recognition of a widely recognized problem. A sense of community is built around the issue, and more people join the movement. This bandwagon effect leads to increased resources and formation of new social norms,

creating a climate that supports individual behavior change as well as social change.

Community and collective action, if implemented successfully, can lead to the following outcomes:

- **Collective or self-efficacy**—the confidence that together coalitions of organizations and individuals can succeed in future endeavors.
- **Sense of ownership**—the degree to which the community, organizations, and individuals perceive themselves as responsible for the program's success and feel they deserve credit and benefits from the program.
- **Social cohesion**—the extent to which members want to cooperate in another collaborative project and the degree to which the social network of the community is interconnected rather than divided into cliques and factions.
- **Social norms**—the accepted rules for participation, especially regarding who should or should not speak up and share in decision making regarding contribution and sharing of benefits.
- **Collective capacity**—the overall ability of a community or alliance to engage in effective dialogue and collective action that is a consequence of the social change indicators.

In emerging democracies where the use of a participatory process of working together is relatively new, decision making and program implementation are being decentralized to district and state levels. Increased information can help to redistribute power. In such settings, networks fostering horizontal communication are replacing a single directive voice, and peers emerge as key sources of information. Grounded in principles that are inclusive and participatory, social mobilization aims to increase civic participation, strengthen organizational capacity for collective action, and foster social empowerment.

Interventions that influence individual behavior change have proven effective. However, interventions aimed at improving women's reproductive health cannot rely solely on influencing individual women because other family members often exert major control over decisions regarding childbearing and reproductive health, including whether women will obtain medical care in obstetric emergencies. When funds are needed for health care, as in the case of obstetric emergencies, husbands and other family members often exert control around decision making.

Many public health and social problems in resource-poor countries require a broader approach that addresses social, cultural, and environmental factors that affect individual behavior. Broader interventions that involve community members, stakeholders, and others at multiple levels are needed because these intractable problems can only be solved through collective action. Also, in some cultures the concept of the individual does not exist or is secondary to the group or community. Thus, it is important to understand how an individual's behavior is shaped by his/her social context and to recognize the influence of local values and social norms on individual behavior.

Due to societal influences on individual behavior, communication should aim to effect broader social change. Key underlying concepts are:

- Dialogue serves as a basis for collective action.
- Information is shared or *exchanged* between two or more individuals rather than *transmitted* from one to the other. No one is a passive receiver of information.
- Importance is given to the participant's perception and interpretation of information and understanding that communication is a process of dialogue or ongoing cultural conversation.
- Communication within a community or group is required to identify areas of agreement and disagreement.
- Socio-cultural context defines targets of opportunity (or barriers) for change.

### **III. APPLYING SOCIAL MOBILIZATION IN NEPAL**

The Centre For Development and Population Activities' (CEDPA's) first major involvement in social mobilization came in 1995, when CEDPA/Nepal joined with the Nepal Red Cross Society (NRCS) and 28 national and local organizations to conduct Nepal's first National Condom Day. Designed to promote condom use for birth spacing and prevention of sexually transmitted infections (STIs) and HIV/AIDS, this event included mass rallies, contests,

games, street dramas, and puppet shows. The results of organizations joining together, standardizing behavior change messages, and mobilizing their community-based networks were impressive.

Within three years Condom Day reached all districts of the country and was institutionalized as an annual national event. Today it involves many multiple national and local non-governmental organizations (NGOs) across the country, with the support of government agencies. CEDPA/Nepal played the main organizing role until 2002, when it turned over this function to the NRCS, which has chapters throughout the country. CEDPA/Nepal's inputs into Condom Day were supported by the ACCESS Project from 1995-1998 and by the ENABLE Project from 1998-2002.

Condom Day became the inspiration for the first safe motherhood collaborative event in 1996. National Clean Delivery Awareness Day, designed to coincide with International Women's Day, reached 41 districts covering more than half the country. It involved the coordinated efforts of 26 organizations and the Family Health Division of the Ministry of Health. This first event included rallies, exhibits, discussions, street dramas, puppet shows, and demonstrations of the clean home delivery kit. Posters, stickers, flash cards, and other promotional materials were widely distributed. The various local events were well-attended and attracted extensive media coverage, thus encouraging the government to initiate safe motherhood actions. A 1997 study found that use of clean delivery kits rose to 28 percent in those areas with safe motherhood events, compared with less than nine percent in two 1996 national surveys.

The organizations involved in National Clean Delivery Awareness Day discovered that such events were low cost, since partner organizations shared costs, human resources, and materials. They also resulted in rapid, widespread dissemination of information materials and key messages, leading to greater public awareness of safe motherhood issues from the grassroots level to the policy level.

This initial success led to the formation of the Safe Motherhood Network (SMN), a coalition of multisectoral local NGOs, government agencies, donors, and international organizations committed to collaborating on collectively focused actions for safe motherhood (Levitt et al. 1997). Initially supported under the ACCESS Project, the SMN has been supported under the ENABLE Project and the MNH Program since 1998.

The founding members of the SMN in Nepal brought together years of experience in reproductive health, community mobilization, advocacy, empowerment, awareness building, behavior change, capacity and skill building, and social marketing. Political commitment to safe motherhood escalated when the Prime Minister's wife, who had recently experienced obstetric complications, agreed to chair the SMN. This combination of expertise and political commitment resulted in a unique approach for addressing safe motherhood.

Over the next few years, the SMN continued to increase its membership, evolve its strategies and expand its mobilization efforts throughout the country. The SMN developed a structure that included an elected chair and subcommittees on advocacy, capacity building, communication, events, and other topics. It was embraced by the government and donors, which contributed to its momentum. During a pivotal workshop devoted to increasing the understanding of actions required to reduce maternal mortality, the SMN walked representatives from the police, armed forces, women's groups, and NGOs through an interactive learning exhibit entitled "The Road to Maternal Survival." This exhibit clearly demonstrated the specific roles and focused actions required by numerous partners at multiple levels and generated several new partnerships for safe motherhood.

The SMN's collaborative approach was globally validated during the Safe Motherhood Conference held in Sri Lanka in 1997, where international safe motherhood experts emphasized the importance of working in partnership in their ten-point call for action.

In Nepal, within a year after the formation of the SMN, Village Development Committees were earmarking funds for pregnancy-related emergencies. The NRCS was invited to help plan the first awareness events for safe motherhood. After becoming involved with the SMN, NRCS managers realized that 60 percent of ambulance calls were for pregnancy-related emergencies. As a result, the NRCS managers understood that their role was integral to birth preparedness and complication readiness (BP/CR). They became active partners and have taken the lead in moving the SMN activities to the district level. Now NRCS builds awareness campaigns about birth preparedness, has strengthened its blood donor system to address the needs of childbirth emergencies, and has started a dialogue on this important topic in remote regions of Nepal.

In collaboration with other SMN members, CEDPA conducted a formal assessment in 1998 to evaluate the impact of the SMN activities implemented in Nepal. The assessment findings were encouraging. There were visible changes in terms of policy implementation, increases in resource allocation, prioritization of safe motherhood by the government, donors, and international and national organizations, and improved understanding among stakeholders of actions required for reducing maternal mortality. Community members residing in areas of SMN activities were aware of the safe motherhood messages. Funds, materials, and human resources for activities had been contributed from almost all SMN member organizations, indicating joint ownership and commitment to the SMN (Shresta et al. 1998).

Today, the Nepal SMN has 30 individual members and 99 organizational members, including NGOs, government officials, professional associations, the media, and donor agencies:

5

## IV. REFINING AND ADAPTING THE SOCIAL MOBILIZATION APPROACH

Based on what they learned through participation in the SMN, two USAID-funded global reproductive health programs – the ENABLE Project and the MNH Program – integrated social mobilization into their activities, thus refining the approach used in Nepal and adapting it to multiple settings.

The ENABLE Project, conducted by CEDPA during 1998–2003, was designed to support women's reproductive health and family planning decision making through building the capacity of NGOs in developing countries to deliver sustainable, quality community-based reproductive health services. Working in five countries (Ghana, India, Nepal, Nigeria, and Senegal), ENABLE also mobilized networks to create an enabling environment in support of positive reproductive health behavior change at family, community, health facility, and policy levels.

The MNH Program, a partnership between JHPIEGO, CEDPA, the Program for Appropriate Technology for Health (PATH), and Johns Hopkins University/Center for Communication Programs (JHU/CCP), aims to

reduce maternal and newborn deaths in the developing world through increased access to, demand for, and use of appropriate maternal and neonatal health care. It emphasizes supportive policies, strong partnerships, and community involvement, with the empowerment of women, participation, collaboration, and equity as the guiding principles. The MNH Program works at the global level and has worked in 13 countries since inception (Afghanistan, Bolivia, Burkina Faso, Egypt, Guatemala, Guinea, Haiti, Honduras, Indonesia, Nepal, Peru, Tanzania, and Zambia).

Building on their past experiences, the ENABLE Project and the MNH Program constructed models of behavior and social change that recognize the multiple factors that contribute to lasting behavior change. In both models the individual woman is one of the stakeholders, reflecting CEDPA's mission that emphasizes women as full partners in development. ENABLE evolved a conceptual framework, known as the "ENABLE egg," which illustrates how women's RH decision making and behavior are immersed within layers of influence and control by family members, the community, and government policies and programs.

As an initial step toward adapting the Nepal approach, ENABLE developed a manual, *Social Mobilization for Reproductive Health: A Trainer's Manual*, for conducting workshops on the fundamentals of social mobilization as it applies to reproductive health. In this manual, social mobilization is defined as "*a systematic process of planned actions to reach, influence, and involve all relevant segments of society across all sectors, from the national*

*to the community level, in order to create an enabling environment and effect positive behavior and social change.*" (CEDPA 2000:9).

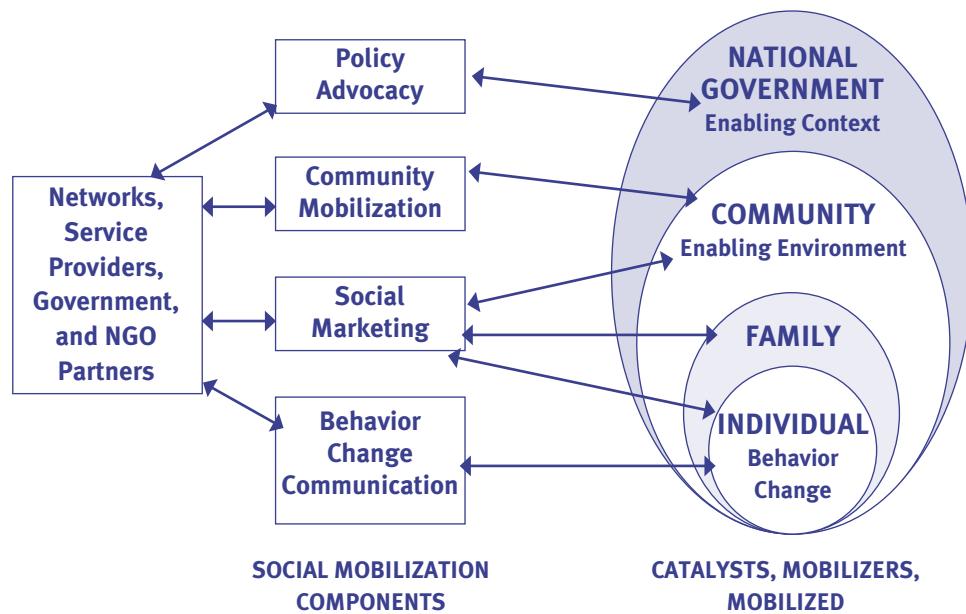
Sections of the manual cover coalition building, gender equity, action planning, stakeholder analysis, message design, evaluation, and campaign planning and implementation. The manual presents social mobilization as a flexible approach that includes elements of behavior change communication, social marketing, advocacy, and community mobilization. The ENABLE Project and the MNH Program have used the manual to train coalitions and others to implement a social mobilization approach.

Forming coalitions or alliances comprised of diverse stakeholders is the foundation of the approach. The training manual provides concrete steps to build coalitions. Other key components of social mobilization include advocacy, resource mobilization, upgrading service delivery, and communication to create demand and promote informed decision making. Published in 2000, the manual was field tested in Nigeria and India.

The ENABLE Project's framework for social mobilization identifies four types of interventions: policy advocacy, community mobilization, social marketing, and behavior change communication (see Figure 1). These interventions are implemented at multiple levels in order to influence individual behavior change and the enabling environment, which includes the family, community, and national government.



**FIGURE 1. THE ENABLE SOCIAL MOBILIZATION FRAMEWORK**

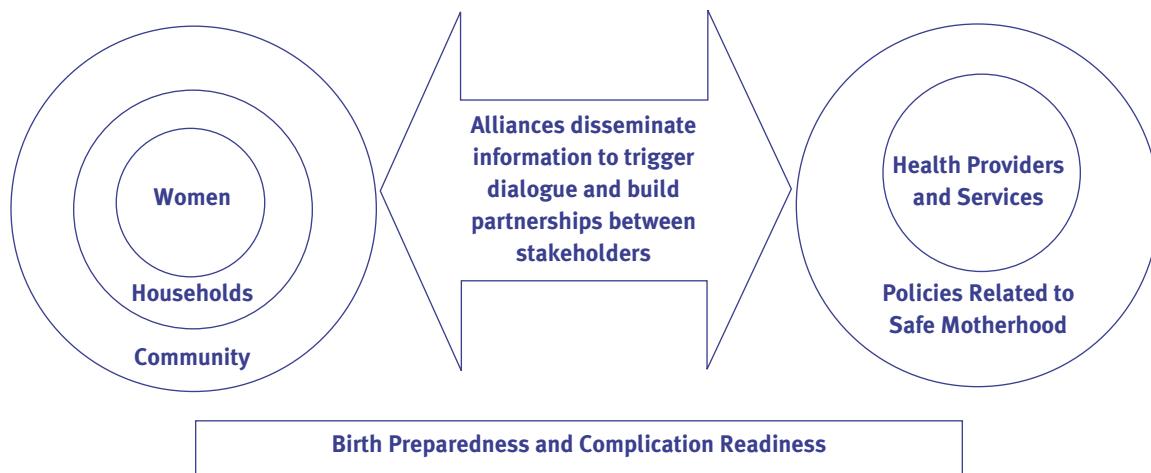


The MNH Program's model for social mobilization is based on the Nepal experience and is built on two cornerstone concepts:

- Focused action - the concrete actions and activities carried out collectively by diverse stakeholders in the short- and medium-term.
- Capacity building - the development of attitudes and skills that are needed to sustain changes over the long term.

The concept of birth preparedness and complication readiness (BP/CR) is central to the MNH Program. BP/CR recognizes that all stakeholders—from the woman to the policymaker—can contribute to actions and practices that will save women's lives (see Figure 2). The ENABLE “egg” is used to describe the same concept—shared responsibility of all stakeholders.

**FIGURE 2. THE MNH PROGRAM SOCIAL MOBILIZATION MODEL**



**Empowering stakeholders—individuals, organizations, health care providers, and policymakers—at all levels to participate in shaping the factors that save women and newborn lives is essential. Stakeholders are viewed as agents—instead of targets—of change. Strengthening their individual and organizational capacities is critical.**

—Nancy Russell and Marta Levitt, CEDPA

## COMMON PRINCIPLES

The MNH Program and ENABLE social mobilization models have several key concepts and principles in common:

- 1. Communication is an integral part of the social mobilization process.** Disseminating messages through multiple channels and encouraging public dialogue helps to educate women, families, providers, communities, and policymakers on the skills and practices needed to improve reproductive health and reduce maternal and neonatal mortality. Improved knowledge can strengthen the appreciation of skilled maternity care and increase support for making these services more widely available. Communication can serve as a basis for dialogue and partnerships between individuals, communities, and healthcare providers in both the public and private sectors.
- 2. Access to evidence-based information is fundamental to behavior change and collective action efforts.** By basing strategies and interventions on the most up-to-date research, champions for change can ensure that their efforts are efficient and that the information and services they provide are of the highest quality possible. Having authoritative research underlying recommended policy changes also helps to convince policy makers to adopt such changes.
- 3. Social mobilization strategies need to be tailored to the local setting.** Social mobilization approaches vary according to the political and cultural context, but at the same time, they should follow a strategic and

systematic plan with a specific outcome in mind. The implementation of the MNH Program and ENABLE models has been accompanied by both international and local technical assistance to provide guidance in alliance formation, strategic planning, and other technical areas. Each country has adapted its strategic plan to its own political and social context.

- 4. Capacity building for social mobilization involves “learning by doing.”** Key stakeholders at multiple levels need to develop key skills, including coalition building, strategic planning, consensus building, networking, community mobilization, advocacy, event organizing and resource mobilization. Materials and manuals can be adapted for use when needed. The *ENABLE Social Mobilization for Reproductive Health Manual* was used in both the ENABLE and MNH Program countries to initiate the concept of social mobilization.
- 5. Social mobilization efforts must provide a safe environment for diverse stakeholders at all levels to engage in dialogue and collaborative actions.** Although evidence exists proving which models/projects work, divergent opinions remain. Sometimes the political environment and cultural norms interfere with implementation of evidence-based best practices. Coalitions of diverse stakeholders can come together to discuss and share opinions and suggest solutions. People also need to recognize their part in the whole picture—stakeholder buy-in is key to successful dialogue and collaboration.
- 6. Social mobilization requires a paradigm shift away from a focus on individual change to a holistic social change.** The ENABLE Project and the MNH Program believe that sustainable behavioral change will come only with a social movement that creates behavioral (and attitudinal) change at multiple levels. This requires focused action and capacity building efforts involving individuals, families, health workers, communities, and policy makers.
- 7. While social mobilization may be initiated at a variety of levels, ownership of the process must be at the local level and tailored to local culture.** In each country ENABLE and the MNH Program had to work with partners on the ground to assess the political and social environment before initiating a plan of action. NGO

and government leaders determined the level of interest in the issues of RH and safe motherhood and whether to initiate mobilization efforts at the community, district, or national levels.

- 8. Social mobilization efforts are based on principles of partnership and collaboration, shared goals, collective identity, and inclusiveness.** The process of integrating these principles into a coalition results in a sense of community around issues and leads to ownership and focused action.
- 9. Donor support and appreciation of the creative nature and long-term, culturally tailored process of social mobilization are essential.** Donors need to recognize that social mobilization takes time to achieve measurable health impacts. It must be valued as a means to broad social change.

Donors have played an important role in social mobilization for reproductive health and safe motherhood. Several international donors are members of national alliances and contribute funds for specific activities. For example, the United Nations Population Fund (UNFPA) and other donors are members of the WRA of India (WRAI) and have contributed to the global WRA as well. The international members of SMN include USAID-funded agencies (CARE, CEDPA, EngenderHealth, JHPIEGO, JHU/Center for Communication Programs, Save the Children, and World Education), Canadian, British, and Norwegian development agencies, and various UN agencies. To avoid the appearance of being donor-driven, coalitions should not rely entirely on external funds for social mobilization activities. Often members of alliances receive funds that they designate for alliance activities.



## V. EFFECTIVE STRATEGIES FOR SOCIAL MOBILIZATION

The ENABLE Project and MNH Program social mobilization strategies recognize social change as critical for lasting behavior change and are recommended based on both projects' experience in the field.

### Initiating Social Change

In order to foster a social change at global, national, and local levels, ENABLE and the MNH Program have observed that the early stages of creating momentum behind a social issue are crucial to create a broad movement for social change. The initiation of coalitions is central to the ENABLE and MNH Program social mobilization approach. Coalition members have to agree that working collectively is necessary to achieve the changes they desire.

Factors that indicate the need for social mobilization are:

- An issue or health problem has not been resolved successfully or improvements are not seen through traditional programmatic interventions.
- Impact requires behavior change at multiple levels of society.
- The issue affects many people nationally and requires multisectoral action.
- The people affected by the problem are vulnerable, marginalized, and least able to make or act on decisions.
- Policies are set but not operationalized or there is a political commitment but little change/achievements towards national goals.
- A need is identified at the grassroots level.
- Individual behaviors have been slow to change.
- Changes occurred in a small area, but guidance to replicate these programs was not shared widely with other grassroots organizations.
- New data indicate that little or no progress has been made in addressing a serious problem.

One or more of these “triggers” can bring groups of people together to plan or build on a special event or activity that will become part of a social mobilization approach. The coalition, formed by organizational representatives, can then use the event, forum, or other activity to serve as a catalyst to build further awareness and strengthen support for the issue.

Organizing special events and campaigns helps to raise awareness and expand support. These activities also help to build trust among coalition members and strengthen their ability to work together. Special events attract media attention, which in turn influences local and national leaders. Typically these events are low cost, since resources among coalition members are shared and existing networks among member partners are used to reach the grassroots. In the experience of ENABLE and the MNH Program, events have often served as catalysts for focused action. For example, commemorating Clean Delivery Day in Nepal sparked the formation of the Safe Motherhood Network. In India, the March to the Taj Mahal raised public awareness of safe motherhood, ultimately leading to the declaration of a National Safe Motherhood Day.

### **Building Coalitions**

Building coalitions is critical to social mobilization because, as the literature suggests, these broader groups expand the sense of community and create a collective identity around an issue (Aubel 2001; Israel 1985). However, communities are not homogeneous; they require dynamic leadership and a process for resolution of conflicts.

Social mobilization campaigns gather momentum when they harness the talents and resources of organizations and individuals from many professions and sectors of society. Reaching beyond the health community helps to extend the reach of coalitions. Similarly, involving the government in social mobilization coalitions and events lends legitimacy to the movement and paves the way for policy change. The White Ribbon Alliance of India (WRAI) has worked closely with the Ministry of Health and Family Welfare, organizing a consensus-building exercise on skilled birth attendants, participating in technical consultations, and helping to organize the first National Safe Motherhood Day. The government has gained access to the WRAI's technical expertise and contacts with NGOs working in India on safe motherhood, while WRAI members have been able to make valuable contributions to government policies and program directions. Similarly, Indonesia's Ministry of Women's Affairs and Social Justice has endorsed the Indonesian WRA.

When a coalition is committed to an issue, such as the reduction of maternal mortality, coalition members may set aside their differences and concern for individual agendas and focus on working in collaboration to achieve shared goals. For example, in India, WRAI members hold differing opinions of the skill level of traditional birth attendants.

However, WRAI members have put aside this potentially divisive issue to focus on promoting evidence-based best practices. The WRAI also encourages the collection of indigenous knowledge, which has led to a better understanding of family decision making during obstetric emergencies. Compromise and mutual respect are essential to maintaining a sense of community around an issue.

In the past, international NGOs have facilitated the formation of coalitions. But once the external agency's involvement ends, the momentum fades away. Thus, it is important to ensure that the coalition and local communities take ownership of the movement and have the capacity to continue it independently.

### **Capacity Building for Sustained Partnership, Collaboration and Collective Action**

To support the rapid expansion of coalitions and accelerate their ability to conduct social mobilization campaigns, sponsoring agencies need to provide resource materials, technical assistance, and training to coalition members.

Access to information is critical to not only strengthening skills but also to increasing the sense that coalitions share an important mission. Materials should be shared among coalition members as widely as possible. Similarly, coalition members should participate in the development of new materials to ensure that they are appropriate for the coalition's diverse constituencies.

ENABLE and the MNH Program developed field guides, information cards, and technical packets. These materials have been distributed widely by NGO partners and organizers of conferences and workshops; electronic copies have been disseminated via e-mail and Internet postings. Meetings and special events became forums for learning and sharing between organizations in the field. ENABLE and the MNH Program's country programs have modeled this process by creating activity guides in multiple languages, standardizing key messages, developing prototype dramas conveying correct messages, and developing contests that support best practices.

The MNH Program is developing a tool kit with tools and guides from multiple sources to guide others in the process of mobilizing around best practices for improved maternal and newborn health. Some of the tools have been adapted from advocacy and community mobilization guides and applied to the Program's social mobilization activities for



safe motherhood. The kit also will include references to other sources that address the various stakeholders from the individual to the policymaker.

Technical assistance is essential to build the capacity of groups to use the methods and tools of social mobilization for focused action. Social mobilization champions for change need to be skilled in various facets of social mobilization, including coalition building, advocacy, community mobilization and organizing, planning issue-based campaigns, team building, networking, strategic communication, behavior change communication, leveraging of funds, media liaison, and facilitation. Each champion for change in the network should be able to: communicate strategically and effectively; mobilize groups at multiple levels; facilitate sharing, participation, and partnerships; and resolve conflict. He/she also needs to be knowledgeable about current technical issues and be up to date on the latest technical evidence related to reproductive health and safe motherhood.

The following are the kinds of technical assistance and other inputs needed to build social mobilization competencies among program staff and NGO partners:

- Training in social mobilization methodologies for reproductive health and safe motherhood;
- On-site technical mentoring and support from international and national experts;
- Sharing of information, achievements, and success stories through print and electronic mechanisms (e-mail, list serves, websites), at regular meetings, and at special events such as conferences, workshops, and symposiums with multi-directional flow of information;

- Dissemination of cutting edge tools, research, and best practices;
- Development of monitoring and evaluation systems; and
- Development of qualitative methods for documenting collective action and assessing the coalition's ability to work together effectively.

### **Extending the Reach through Social Mobilization**

Effective social mobilization seeks to institutionalize changes, which usually entails changing government policies, health programs, and/or normative health practices. Thus, involving government officials at all levels and identifying specific changes are important steps in securing policy change. In Burkina Faso, the community health volunteer committees have organized local, regional, and national events to raise awareness about safe motherhood. Leaders of these committees are now monitoring their health facilities to ensure quality service for their communities while ensuring that policies are implemented and enforced.

Just as social mobilization depends on building a diverse coalition, it also serves as a platform for airing diverse opinions. Increasing the level of dialogue and allowing full discussion of the issues is a key part of the process of consensus building. The WRAI sponsored a symposium on home birth where government officials, NGOs, donor agencies, individuals, and community TBAs debated the issue of home birth openly. These types of open forums bring together on a single platform those working on the front lines of safe motherhood with the technical experts, providing opportunities for sharing of opinions and experiences, negotiation and consensus building, and merging academic theory and scientific evidence with field based realities.

Events such as public forums and fairs are an important part of social mobilization because they raise the profile of issues and lend them legitimacy. Program implementers should think of events as catalysts for future actions, rather than as one-time occurrences. Each event should be used to build momentum to reach more people, expand activities into new areas, enlist new partners and champions for change, and involve higher-level officials and well-known celebrities in activities. Often local organizations will need technical assistance to use events as a springboard for further public outreach.

## VI. MONITORING AND EVALUATION

Monitoring and evaluation (M&E) are essential in order to assess the impact of interventions, determine which actions are effective and which are not, make decisions regarding mid-course corrections in the program, and plan for follow-on activities. Monitoring and evaluation should be an ongoing, participatory process that produces both qualitative and quantitative information. The MNH Program and the ENABLE Project have relied mostly on monitoring and documentation rather than in-depth evaluations due to the relatively short duration of their interventions.

The first step in developing an M&E plan is for program stakeholders to identify program goals and benchmarks for success. They also need to recognize that information to meet donor requirements must be collected as well. From these elements, they can create indicators to track progress.

Project outputs should be regularly monitored and documented so that their effectiveness and reach can be assessed. The MNH Program has worked with the WRA to develop monitoring tools to track the progress of alliance members. These tools can be adapted to local contexts to capture such information as the number of members, events, funds raised, and policies changed. Collecting information is time-consuming, and thus it is important that members understand the value of this information to them. Changes in policy are often visible within the first three to four years of project interventions. Building a sense of community among alliance members and changing community attitudes and norms take longer and thus are more difficult to document well within typical project timelines.

In the MNH Program's social mobilization framework, it is important to monitor both the focused actions, including activities and results, as well as the capacity of the alliances to work collectively. The MNH Program developed the Birth Preparedness and Complication Readiness (BP/CR) Matrix as a framework for identifying the necessary focused actions of all stakeholders before, during, and after delivery. The MNH Program has used the BP/CR Matrix as a tool to identify key actions and behaviors that can improve outcomes for women and newborns. The desired behaviors for safe motherhood are listed under policymakers, health facilities, providers, communities, families, and women.



The MNH Program is also developing a tool to monitor BP/CR. This tool establishes indicators based on the actions recommended across the six levels and helps safe motherhood programmers to determine whether change occurred. However, it does not address any characteristics of the process that explain how change resulted, or why no change occurred.

Following are some aspects of the process of collective action that should be documented, if possible:

- **Leadership**—the extent of leadership; equity and diversity, flexibility, competence in encouraging and securing dialogue and action, vision and innovation, trustworthiness and popularity;
- **Degree and equity of participation**—access to participation, and extent and level of participation;
- **Information equity**—awareness and correct knowledge about the issues, and enhanced flow of information;
- **Collective self-efficacy**—perceived efficacy to take action as a group, perceived capability of other community members, and perceived efficacy to solve problems as a group;
- **Sense of ownership**—importance of the program to participants, sense of responsibility for the program, contribution to the program, benefit from the program, participants' sense of ownership of either credit or blame in the program outcome, and personal identification with the program;
- **Social cohesiveness**—sense of belonging, positive morale, goal consensus, trust, reciprocity, and network cohesion;
- **Social norms**—norms on participation, norms about leadership, and norms about the issue;
- **Capacity building**—the number and type of capacity building products developed and disseminated—tools, technical papers, guidelines, advocacy, behavior and

social change materials, manuals; number and type of capacity building events for social mobilization; number and type of persons participating in social mobilization capacity building events; increased capabilities of participating organizations; number and types of programs putting learning into action following capacity building; and

- **Focused action at multiple levels**—the extent to which focused actions and messages are based on the evidence; changes in policies and programs in line with social mobilization messages; number and reach of programs replicating evidence-based practices; number of new partnerships established to implement focused action; amount of resources and funds leveraged for events and focused actions; behavior change among key stakeholders—individual women, family members, community, providers, planners, and policy-makers—in line with social mobilization messages.

The MNH Program will include suggested tools to monitor these characteristics in its new resource materials. All types of documentation, news clippings, photos, and other reports will help to track the progress of a coalition and contribute to coalition members' sense of success as well as tracking their impact in effecting change.

In order to foster partnerships and inspire future action, the monitoring process should use effective tools that foster dialogue and the sharing of experiences to determine lessons learned and next steps. One of the challenges confronted by ENABLE and the MNH Program was the limited number of existing tools specific to social mobilization. Consequently, ENABLE, the MNH Program, and their partners developed several M&E tools, including:

- **Tools for strategic planning related to the MNH BP/CR Matrix.** These tools are participatory and help stakeholders to use the matrix as a means of planning activities based on priority actions they agree on together.
- **Group exercises for analyzing the effectiveness of social mobilization activities and developing lessons learned.** There are a number of tools for community mobilization and advocacy that will be summarized and referenced along with others that have been developed specifically around the ENABLE and MNH Program social mobilization experiences.
- **Monitoring forms.** These forms were designed

by the MNH Program and the WRA to be used by alliances to quantify changes at multiple levels. The tool kit will give guidance as how to use these tools for documentation that helps to guide coalitions in their development.

Social mobilization activities need to be carefully documented in order to continue improving upon and evolving the strategy. To capture these valuable outcomes, creative and participatory monitoring, evaluation, and documentation methods are needed. The anecdotal evidence and literature support the assumption that advocacy efforts help achieve information equity. However, social mobilization is a long-term process that will require ongoing monitoring, evaluation, and documentation to determine results.

## VII. REPLICATING THE MODEL

Following the Safe Motherhood Conference held in Nairobi in 1987, international and national agencies joined together to ensure the reduction of maternal mortality worldwide. Yet a decade later maternal mortality rates had not significantly changed. In 1999 a few international agencies recognized the critical need to mobilize from the grassroots level to the global level by broadening the partnerships. This recognition led to formation of the White Ribbon Alliance.

### White Ribbon Alliance – A Global Movement

Formed in 1999 following a series of meetings involving international NGOs and donors, the WRA served to raise the profile of safe motherhood at international and national levels. The white ribbon, modeled after the insignias for HIV/AIDS and breast cancer, became a widely recognized symbol for the movement.

The ENABLE Project and the MNH Program were instrumental in the founding of the WRA and took on leadership roles. The WRA provided a mechanism for globalizing the ENABLE Project and the MNH Program social mobilization approach to safe motherhood. Many of the tools and methodologies from Nepal, including the use of special events as catalysts for action, were adapted by the WRA in national campaigns.

The ENABLE Project implemented social mobilization strategies through the WRA in Ghana, India, and Nigeria, while the MNH Program built alliances in Burkina Faso, Indonesia, and Zambia. ENABLE and MNH also became

technical resources for international, national, and district WRA efforts and helped to launch the WRA in Ba Zhong, China. As members of the global WRA, ENABLE and the MNH Program have helped to produce materials, review technical documents, and develop monitoring and evaluation tools to be used at the country level where alliances are being initiated.

The ENABLE/MNH Program social mobilization approach through the WRA has fostered numerous activities to disseminate and replicate safe motherhood evidence-based practices. In October 2002 the WRA in India, in collaboration with the global WRA and with support from 11 WRA member agencies, organized an international conference, “Saving Mothers’ Lives: What Works.” The 467 conference participants came from 35 countries and included safe motherhood experts, national and state level government officials, midwives, doctors, communication specialists, NGOs, social mobilization specialists, and traditional birth attendants. This conference provided a forum for dialogue, sharing of research findings, best practices and lessons learned, exchanging of materials and tools and further escalated energy for the global safe motherhood movement.

Recognizing the need for grassroots NGOs to have access to information on implementing evidence-based safe motherhood practices, the WRA/India produced a field guide, *Saving Mothers’ Lives: What Works*. ENABLE, ICICI Bank, the MacArthur Foundation and its other members provided technical and financial support for the guide. Much of the evidence and guidelines drew upon experiences, documents, and information disseminated through the MNH Program, ENABLE, and global WRA partners such as the World Health Organization (WHO). The field guide is available in English, French, and Hindi. This publication and the conference have spurred many organizations and governments into action.

## COUNTRY-LEVEL WRA ACTIVITIES

### Burkina Faso

In Burkina Faso, the MNH Program worked through a community mobilization approach in local communities prior to building an alliance that involved community and political leaders. Activities have been focused in Koupela District, which has high maternal mortality and very low awareness of the need for maternity care. Community advisory groups (COGES) undertook a Performance Quality Improvement (PQI) study to analyze the situation

## A CHAMPION FOR CHANGE IN KOUPELA, BURKINA FASO

Gabriel Yougma, a retired police captain and treasurer of his community advisory group, was instrumental in advocating for safe motherhood. In addition to serving as treasurer of the White Ribbon Alliance for Safe Motherhood, he was elected to head a pilot group of management committees called Nayolsba. This group works to increase access to emergency care and reduce costs of patients who are evacuated.

A challenge arose in early 2003 when the only anesthetist in the district of Koupela was reassigned to another district without being replaced – thus halting all surgeries at the district hospital. Mr. Yougma personally contacted the Secretary General of the Ministry of Health, who promised to expedite the search for a new anesthetist. Mr. Yougma’s appeal was unusual because he took the initiative to directly contact an official instead of following a lengthy bureaucratic process.

In the meantime, Nayolsba supplemented the cost of evacuation for every patient who needed emergency care. This support enabled a young pregnant woman, Sana Rihanata, and her baby to be saved. Suffering from obstructed labor and fetal distress, she was referred by the local health center to the National Hospital. Thanks to support from Nayolsba, she was able to reach the hospital and delivered a healthy baby girl by cesarean section.

To date, 16 people have been transported with funds from Nayolsba, and a new anesthetist is now working in Koupela thanks to the extra effort of Gabriel Yougma.



and seek solutions. This process triggered the first public awareness event, held in March 2002. This effort in Burkina Faso gained global attention by winning the global WRA award in June 2002.

In 2003, activities were scaled up on International Women's Day. Lessons from the previous year helped to shape the events. Key stakeholders from throughout West and Central Africa were in attendance. A district-wide WRA contest based on the global model was held in Koupela, and three COGES were awarded prizes for their efforts. The WRA in Burkina Faso was able to reach more people and involve more partners in the process. COGES are now working together, using standardized messages and actively participating in improving facilities and involving the community in preparing for safe childbirth.

## India

The White Ribbon Alliance of India (WRAI) focused on creating widespread awareness among policy makers, program planners, opinion leaders, media representatives, and community members. In March 2000 coalition members launched their first campaign, which reached more than 9,000 people in 13 states and attracted extensive newspaper, television, and radio coverage throughout India. Adapting materials from Nepal, the coalition developed a campaign guide for grassroots NGOs and media kits and distributed them throughout India through partnerships, networks, and e-mail. The campaign used powerful imagery, equating the number of maternal deaths to 600 airplane crashes every year.

This burst of publicity led to heightened interest in the issue of safe motherhood, and the WRAI soon grew to include 60 organizational members. To facilitate expansion, the WRAI developed guidelines for establishing a WRAI state branch. These guidelines emphasized the principles for coalition building, such as inclusiveness, collaboration and partnership, sharing of resources, and volunteerism. When a NGO from a state showed interest, a member of the central WRAI was assigned to be its mentor. There are currently five state WRAI branches comprised of 105 local organizational members.

The WRAI has implemented several high-profile social mobilization events—the 2001 March to the Taj Mahal (chosen for its symbolism, since it was built in memory of a woman who died in childbirth), the 2002 International Safe Motherhood Conference, the declaration and launch of a National Safe Motherhood Day in 2003, and a rally at India



Gate. All of these were well attended by diverse stakeholders from high-level officials, ministers, and celebrities to grassroots workers. They drew national and international media coverage, elevating the issue of safe motherhood to one of the most visible national priorities. These events were part of a strategic plan and have become catalysts for further action.

Through monthly meetings, symposia, and conferences, the WRAI has created a safe environment for dialogue and the sharing of global and local best practices, innovative program activities, research findings, information, and products. Sub-committees have formed on specific action topics such as skilled birth attendance and birth preparedness and have produced various technical papers, evidence-based technical guidelines, a best practices field guide, BP/CR communication material, and the first commercially marketed Clean Delivery Kit in India.

Several of the interventions advocated with the government are being initiated: training of non-specialist physicians in administering anesthesia, training of auxiliary nurse midwives and community-based skilled birth attendants in midwifery life saving skills, and provision of blood storage units at all operational referral units. The WRAI has become recognized as a technical expert group for the government of India. Its members and leaders are called upon to give technical guidance in program design and to organize technical meetings on safe motherhood. It has become well respected for its capacity to organize and mobilize.

WRAI used the ENABLE/MNH Program principles for implementing social mobilization events, including the development of strategic plans, the pooling of resources, and maintaining shared ownership and collective responsibility for all events. The initial funding lasted for more than two



years as a result of successful leveraging of funds from various donors and member organizations for WRAI events and products. Fourteen organizations currently contribute financially to WRAI. WRAI won WRA's Global Safe Motherhood Award in 2000 and 2003.

In India, as a result of much lobbying by the WRAI and its members, the government is now preparing to create community-based skilled birth attendants and has consented for the first time to incorporate midwifery life-saving skills into the pre-service education course. In addition, on National Safe Motherhood Day, the Minister of Health announced a Maternity Benefit Scheme that provides financial support to women for antenatal care and institutional deliveries, including money for transportation and to traditional birth attendants (TBAs) who accompany women to the hospital.

### Indonesia

Indonesia's historical commitment to safe motherhood, a newly emerging democracy, and decentralization provided a strong platform for adapting the social mobilization approach to meet Indonesia's needs. National-level NGOs and government representatives from the Ministry of Health and Ministry of Women's Empowerment joined together to form a national WRA in 1999. The idea of being part of a global movement appealed to the Indonesian representatives.

The Indonesian WRA, known locally as *Pita Putih*, now has over 100 member organizations, with affiliates at district and community levels throughout the country. In 2002 the Ministry of Health, Ministry of Women's Empowerment and the Coordinating Ministry of Peoples Welfare officially endorsed *Pita Putih*. Through the global WRA, *Pita Putih* is also able to share its lessons learned and have access to the latest information in the field of safe motherhood.

### MESSAGE DISSEMINATION LEADS TO ACTION

The WRA in Indonesia (*Pita Putih*) includes many religious groups. Religious leaders are trusted members of the community and are important leaders to involve in the alliance. Special materials have been developed through *Pita Putih* for the Koranic reading groups to disseminate birth preparedness and complication readiness messages.

During the past year a religious teacher was contacted in the middle of the night to help a neighbor who was having a difficult labor, and the midwife was not available. Recognizing the emergency, he mobilized other neighbors, including members of *Pita Putih*, organized transportation and accompanied the woman to the closest health service. When it was realized she needed another level of care, the team of neighbors accompanied the woman and her husband to the hospital, where she was refused care due to lack of funds. The men advocated for the woman and accessed an emergency fund established at the Islamic boarding school.

In this case it is apparent that messages that were incorporated into religious teachings became powerful tools for action. Religious leaders can be a powerful force to ensure that policies are not abused and that all women receive care. The national alliance with district and community roots can save lives.

MNH Program staff in Indonesia provided technical support for social mobilization as well as information on birth preparedness and complication readiness. With M NH Program assistance, the WRA organized a special event to call attention to safe motherhood. Kartini Day, which is celebrated every year to recognize a famous woman change agent, was chosen for the event because WRA members wanted to call attention to the fact that Kartini died needlessly in childbirth. The maternal mortality ratio in Indonesia is 396 per 100,000 live births meaning that two women die every hour from pregnancy or birth complications. Mass media messages complemented the activities of the event and were used as means of stimulating dialogue and conveying how serious this problem is.

The WRA in Indonesia has increased budgets for safe motherhood in several districts, inspired BP/CR systems in communities, and leveraged resources from government and NGOs to build alliances that reach from the national to district and community levels.

## Zambia

The MNH Program in Zambia began in early 2000, when USAID/Zambia and the Ministry of Health asked the MNH Program to provide technical expertise in maternal and neonatal health. The MNH Program has worked on three main fronts in Zambia: strengthening service delivery through pre-service education, behavior change interventions, and policy and advocacy development. In May 2000, a group of Zambian government and NGO leaders were inspired to form a WRA after participating in an NGO Networks for Health Safe Motherhood Conference in Nairobi, Kenya. The Zambia White Ribbon Alliance for Safe Motherhood (ZWRASM) was formed in 2001 with the theme of *Every Pregnancy is At Risk*. Special events were used to initiate the concept of an alliance, to build trust among partners, and to create widespread awareness of issues related to safe motherhood.

Since the formation of ZWRASM, developing, establishing, and expanding the network has been a key MNH Program focus in Zambia. Strengthening the capacity of the NGOs and community-based organizations (CBOs) that are members has also been a key focus. The MNH Program supports a network coordinator to provide the necessary communication, strategic planning, and coordination for ZWRASM. Housed in a local NGO, the ZWRASM secretariat disseminates job aids, orientation packages, tools, and other materials.

To increase activity impact, ZWRASM developed a mobilization toolkit consisting of a simple package of technical information on safe motherhood and ideas for how to plan and carry out social mobilization activities. Guidelines for conducting group discussions, scripts for community theater, and information on birth planning were also included. The toolkit has been shared with WRA members worldwide. The WRA in Burkina Faso adapted it for use in its mobilization efforts. This type of south-to-south exchange has been a valuable contribution of ZWRASM.

In 2001, ZWRASM sought to involve the media in safe motherhood by holding a competition for journalists, inviting them to submit stories and case studies. Many



submissions were received and appeared in local media. The national White Ribbon Campaign in 2002 was coordinated in conjunction with the Zambia Nurses Association, an Alliance member. Nurses and midwives were highlighted during the campaign that celebrated Mother's Day and Nurse's Day together.

ZWARASM has been able to leverage additional funding from partner organizations. It has been invited to help implement the UNFPA and UNICEF five-year country programs and a two-year WHO program. It will coordinate social mobilization and capacity building activities in various areas of the country. ZWRASM has also become a collaborative partner on several reproductive health and infection prevention subcommittees as well as the National Postabortion Care Task Force.

## VIII. OTHER APPLICATIONS OF THE SOCIAL MOBILIZATION APPROACH

### India

In 1998 when ENABLE was initiated, the State Innovations in Family Planning Services Agency (SIFPSA), the implementing agency for USAID's 10-year reproductive health project in Uttar Pradesh, was looking for innovative methods that would accelerate reproductive health behavioral change on a large scale. SIFPSA agreed to be the first to test ENABLE's *Social Mobilization for Reproductive Health Manual*. The four-day workshop brought together participants from NGOs, dairy cooperatives, industries, women's groups, training centers, and SIFPSA. This highly successful workshop triggered numerous social mobilization

efforts in Uttar Pradesh. For example, SIFPSA's very successful tetanus toxoid campaign implemented in half of the state activated many organizations to immunize pregnant women. In just two years, the proportion of pregnant women receiving two doses of tetanus toxoid rose from 41 percent to 63 percent (USAID/India 1998 and 2002).

## Nigeria

In Nigeria, CEDPA's coalition-building activities were widely adopted and have led to a strong network of organizations that both mobilize and advocate on a wide range of issues, from women's reproductive health to their participation in the political process. By linking grassroots advocacy groups with professional women's organizations, the networks have had the visibility and clout to gain passage of legislation in several states. These approaches are bottom-up and participatory and can be applied to a variety of issues and settings.

CEDPA began organizing women's organizations into active coalitions in Nigeria in 1997. Initially funded under USAID/Nigeria's democracy and governance program, the 100 Women Group structure was designed to increase women's political participation and enhance their economic status. A 100 Women Group is an assembly of women who represent 10 to 15 community-based organizations. Representatives from each community level 100 Women Group join forces at the state level, while state level groups work together on national level issues. Thus, the 100 Women Group structure provides a mechanism for community level concerns to be reflected at state and national level. In this process, the 100 Women Groups build consensus among women and

proactive coalitions. It was a concept that empowered women at various levels to collectively articulate their needs and identify strategies to address those needs. The strategy created a critical mass of politically sensitized and mobilized women, thereby connecting women's issues to the

political process. It provided the opportunity for women's voices to be heard.

CEDPA initially worked with five women's organizations. By 2000, the networks had 105,568 members in 686 groups. Most of the groups were not organized or funded by CEDPA. Women's organizations learned of the 100 Women Groups' activities and adapted the strategy to meet their own needs. ENABLE's funding for 100 Women Groups ended in 2001, but the groups continue at approximately the same level of involvement today. Men have begun to join the groups as well, since the groups are perceived as a major force for social change.

The 100 Women Groups have influenced reproductive health in many ways, including increasing women's awareness of family planning, national immunization days, safe motherhood, and HIV/AIDS prevention. The groups have also addressed traditional practices such as female genital cutting (FGC), preventing forced marriages, promoting girl child education, and educating others about obstetric fistula. Five states—Cross Rivers, Edo, Enugu, Ogun, and Rivers—have passed laws banning FGC, largely as a result of pressure from 100 Women Groups, which organized educational campaigns and advocacy visits to local, traditional, and religious leaders, as well as to State Assembly members. In Kano State, government leaders acknowledged the importance of safe motherhood and other women's health issues after a campaign conducted by 100 women group members.

In 1999, CEDPA/ENABLE launched the Engendering Legislative Issues program to bring women's issues into the legislative agenda. The program brought together professional women's organizations to address issues affecting women through state level advocacy and legislative action. Women lawyers and journalists collaborated with women's organizations to draft legislation, promote media coverage of women's issues, mobilize large gatherings of women, and meet with high ranking politicians and opinion leaders. These collaborative activities have contributed to the passage of legislation on FGC, harmful widowhood practices, early marriage, girls' education, and trafficking of women in several states. They have also helped to strengthen the linkages between women leaders and grassroots constituencies. Some 100 Women Group members have been elected to political office, while many women organizations were involved in monitoring the polling stations during the 2003 elections.



CEDPA/ENABLE introduced its Model Local Government Council initiative in 2001. The program, which covers 12 local government areas representing the six geo-political zones, is designed to create and catalyze the emergence of good governance models at the local levels. It promotes fiscal and programmatic accountability and transparency, civil society participation in the governance process, and constructive engagement between government and civil society. Thus, women's influence is seen at various level of government, and women are active participants in building more democratic and stronger government institutions.

## IX. CHALLENGES AND LESSONS LEARNED IN SOCIAL MOBILIZATION

### Challenges

Social mobilization requires a great deal of commitment, dynamic leadership, and broad-based ownership. Country experiences vary and the process is not without challenges. Securing commitment from donors, governments, NGOs, and communities can be difficult—though once in place provide a healthy platform for continued growth and future sustainability. Other challenges may include: ensuring that efforts are working at all levels, gaining and maintaining organizational commitment, finding creative approaches to document and measure success, and capturing results that all stakeholders will value.

Maintaining a collective identity at the expense of individual and organizational recognition is also challenging. As events unfold, organizations become reluctant to give up their name recognition in the name of the greater alliance. This leads to conflict and must be resolved within the alliance.

Charismatic people and their organizations have historically led social movements. However, charismatic leadership is difficult to transfer, both at the central level and throughout all the levels of an effective social movement. Ensuring that leadership is egalitarian and participatory is also challenging, since strong leaders are often accustomed to making unilateral decisions. To ensure that social movements grow and thrive, leaders of NGOs, government agencies, and international organizations must take responsibility for identifying leaders, grooming them for leadership positions, and ceding power when they are ready to take on greater responsibilities.

Other challenges to conducting social mobilization are:

- **Sharing power.** Social mobilization provides opportunities for people with little or no power to work in partnership with power brokers. Marginalized groups can make their voices heard, even when they were previously ignored. Thus, beneficiaries can be brought into the movement to create social change and provide valuable insights regarding appropriate ways of improving services for their group.
- **Maintaining focused actions.** Social mobilization relies heavily on special events to raise awareness and focus the efforts of coalition members. If attention is focused solely on each event rather than seeing events as elements of a larger strategy, then the momentum of an expanding social movement reaching ever more diverse constituencies can be lost. Coalitions need to institute a participatory evaluation process that is reflective and allows future planning. Keeping focused on the larger goal also helps to avoid diluted messages, in which the main themes fade as each member of the coalition adds its own interpretation.
- **Ensuring technical accuracy.** Program leaders need to ensure that technical experts remain involved in the movement to ensure that technical knowledge is up to date and messages and interventions are evidence-based. At the same time, the coalition needs to broaden its base to encompass members from various sectors and communities, so the group should not be overly dominated by technical experts.
- **Adapting to local conditions.** Conducting social mobilization in non-democratic countries can be done, but it requires sensitivity to local norms and special efforts to ensure participatory involvement of coalition members. Technical assistance from external experts can help the process.
- **Measuring results.** The monitoring and evaluation of social mobilization remains a challenge. The activities and results at the policy and service level can be monitored and collected. However, the process indicators for the capacity of coalitions to work together remain a challenge. New methods of monitoring and documentation are needed to capture the results from the individual to policy level as well as the capacity for collective action.

## **Lessons Learned**

From their field experience over the past five years, the ENABLE Project and the MNH Program have identified some lessons learned that are applicable to international agencies providing technical assistance and other support to social mobilization programs:

- Having skilled communication and mobilization staff on the ground is critical. Their technical assistance helps to ensure that best practices in RH/safe motherhood and social mobilization are in place.
- Donor partnership, appreciation, and support of the process are critical. Donor interest can be created if social mobilization goals and efforts relate to donor strategic objectives and are directed at accelerating action or results that donors are trying to achieve.
- Periodic technical assistance and mentoring from an expert in the field of social mobilization assists the technical staff on the ground to implement the ENABLE/MNH model of social mobilization.
- The social mobilization approach can be initiated at the national level and have impact at district and community levels, and can facilitate information equity through broad dissemination of information, triggering dialogue beyond the target areas of alliance members.
- A concept from outside the country can be shared and adapted to meet the needs of the country.
- Social mobilization uses participatory methods to ensure that the strategies employed are complementary to existing work in the country.
- Alliances can be effective in accelerating advocating through ever-growing networks, improving services as well as affecting policy change, programs, practices, and behavior.

## **X. CONCLUSIONS**

Social mobilization is a synergistic approach to social change that galvanizes the strengths of multiple and diverse partners to reach a common goal. It is based on community building, social change theory, communication strategies, and the dissemination of information to trigger dialogue and broaden the base of stakeholder support.

The ENABLE Project and the MNH Program adopted a social mobilization approach in recognition that no single intervention was sufficient to address the many factors

affecting reproductive health and maternal mortality. The social mobilization approach they have used builds on UNICEF's successful work in the 1980s in which behavior change communication, advocacy, alliance building, and the mobilizing of resources were used to build a popular base of support for child survival interventions. The approach also draws on CEDPA's experience in the late 1990s with the Safe Motherhood Network (SMN) in Nepal, where pressure through partnering pushed dormant policies into action and the SMN became part of the government's 15-year plan.

Multisectoral coalitions or alliances are the mechanism for the ENABLE Project/MNH Program approach, fostering local capacity and ownership, shared commitment, and accountability for health issues in the local context. Communication strategies are central and are used to disseminate information and stimulate dialogue to build ownership of issues and foster collective action.

The ENABLE Project/MNH Program approach to social mobilization has been used to ignite change from the grassroots level to the global level, by capitalizing on existing events and holidays to build constituencies and mobilize for long-term action. In India, a march to the Taj Mahal led to the declaration of National Safe Motherhood Day and the incorporation of evidence-based practices by the government. Similar national and district level events in Burkina Faso, Indonesia, Nepal, and Zambia have been the catalyst for increased funding for safe motherhood, new champions for change, and improved services at the community level. In Nigeria the networks and alliances of the 100 Women Groups continue to advocate for change at the policy level. The global WRA, with leadership from the ENABLE Project and the MNH Program partners, grows and is strengthened by south-to-south exchange and partnership. Social mobilization activities have sparked collective action for safe motherhood and reproductive health that can be the driving force behind lasting change.

The ENABLE Project and the MNH Program have successfully used social mobilization to create movement behind long-dormant reproductive health issues and lend them a new sense of urgency.

## GLOSSARY

*Advocacy* – “Advocacy is a set of targeted actions directed at decision makers in support of a specific policy issue.” (POLICY Project 1999, III-2)

*Behavior change* – A non-linear process that includes several intermediate steps through which people move before they change their behavior. These steps include: knowledge, approval, intention, practice and advocacy.

*Behavior change communication (BCC)* – This approach is designed to achieve measurable objectives, reach and involve specific audiences and position health practices persuasively as a benefit in the minds of the intended audience. People at different stages in the behavior change process may constitute distinct audiences and require different messages and different approaches, whether interpersonal communication, mass media or community mobilization. The key program elements of BCC are:

- Audience participation
- Recognition of behavior change as both a social and individual process
- Use of multiple mass media channels
- Development of entertainment for educational purposes

*Campaign* – A set of organized activities, directed at a particular audience for a specific period of time to achieve a particular goal. Communication campaigns often use mediated messages as part of or all of their organized activities.

*Champion for change* – Individuals or organizations willing to take calculated risks to initiate social change. In social mobilization these individuals or organizations are willing to work collectively for change.

*Coalition* – An action-oriented group of individuals and/or organizations working together in a coordinated fashion toward a common goal.

*Collective action* – A focused activity that an alliance plans and implements jointly to achieve a common goal.

*Common issue* – A well-defined social or demographic unit involving a neighborhood or people who share a common issue or interest. Communities are not homogeneous, but they are inclusive, complex, dynamic, and multidimensional.

*Community* – Community can be defined as a geographic locale or as a group of people working toward a common issue.

*Community mobilization* – A process of problem identification and problem solving stimulated by a community itself or facilitated by others that involves local institutions, local leaders, community groups and members of the community. “Community mobilization uses deliberate, participatory processes to involve local institutions, local leaders, community groups, and members of the community to organize for collective action toward a common purpose. Community mobilization is characterized by respect for the community and its needs.” (CEDPA 2000).

*Efficacy* – One’s perceptions of his/her own capabilities; formed through experience, observation, social influence and emotional states.

*Empowerment* – Empowerment is at once a personal and a group process through which people become strong enough to participate within, share in the control of, and influence events and institutions affecting their lives. One cannot empower someone else, but is something that people do for themselves.

*Geographic locale* – A place or small geographical area; a group of people sharing some interest; or a social network of relationships at a local level. Community means more than just people who live close together; it implies sharing and working together in some way. People can live in the same village but be divided in interests and share little in common.

*Information equity* – an outcome when information flows and is disseminated through culturally and politically appropriate methods that increase awareness and correct knowledge about issues by all stakeholders from grassroots individuals and communities to providers and policy makers.

*Media campaign* – Communication campaigns that use mediated messages as part or all of their organized activities.

*Organizational capacity* – A potential state for organizations to identify, mobilize, and address social and public health problems.

*Participation* – A process through which stakeholders influence and share control over development initiatives, decisions and resources that affect them. Participation can take different forms, ranging from information-sharing and consultation methods, to mechanisms for collaboration and empowerment which give stakeholders more influence and control

*Participatory process* – Members of a community actively collaborate in the identification of problems collection of data, and analysis of their own situation in order to improve it. Thus it is a process that involves research, education and action.

*Social marketing* – The use of modern marketing principles and methodologies to increase the use of a socially beneficial idea, product or practice; key features include a thorough understanding of the target audience, creation of beneficial exchange relationships to influence audience behaviors, and an management approach characterized by continuous monitoring and alteration of interventions as needed.

*Social mobilization* – The use of planned actions and processes to reach, influence, and involve all stakeholders across all relevant/pertinent/involved/concerned sectors, including the national and the community level to raise awareness, change behavior, change policy, demand a particular development program, or reallocate resources or services.

*Sustainability* – Sustainability is the capacity of an institution and its reproductive health program to provide its current and potential clients the information and services necessary to obtain the benefits of maternal and child health, including family planning, on a continuing basis beyond the project period with adequate income from diversified financial resources (Hare and Khan 2003).

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**Headquartered in Washington, DC, CEDPA is an international nonprofit organization that seeks to empower women at all levels of society to be full partners in development. Founded in 1975, CEDPA supports programs and training in leadership, capacity building, advocacy, governance and civil society, youth participation and reproductive health.**



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This publication was made possible through support provided by the Bureau for Global Health, U.S. Agency for International Development, under the terms of Cooperative Agreement Numbers HRN-A-00-98-00009-00 and HRN-A-00-98-00043-00. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.



JHPIEGO is a nonprofit international health organization dedicated to improving the health of women and their families. Established in 1973, JHPIEGO – an affiliate of Johns Hopkins University headquartered in Baltimore, Maryland – works in more than 30 countries through its collaborative partnerships with public and private organizations, and local communities.



The Maternal and Neonatal Health Program (MNH) is committed to saving mothers' and newborns' lives by increasing the timely use of key maternal and neonatal health and nutrition practices. The MNH Program is jointly implemented by JHPIEGO, the Johns Hopkins University/Center for Communications Programs, the Centre for Development and Population Activities, and the Program for Appropriate Technology in Health.

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