ACQUIRE Project Working Paper

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The Active Community Engagement Continuum

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The ACQUIRE Project

EXECUTIVE SUMMARY

In 1997, the Centers for Disease Control and Prevention (CDC) formed and led a committee that developed principles for community engagement for public health (CDC/ATSDR Committee on Community Engagement, 1997). The committee defined community engagement as "the process of working collaboratively with groups of people affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being" (CDC/ATSDR Committee on Community Engagement, 1997). This definition has been adapted by the ACQUIRE Project[1] and served as the basis for the development of the Active Community Engagement (ACE) Continuum.

Through the ACQUIRE Project, we have learned many lessons about the processes and outcomes of engaging communities in reproductive health (RH) and family planning (FP) programs. Although empowerment is usually not a planned outcome in RH/FP projects, there is growing evidence that empowerment and health outcomes are related (Wallerstein, 2006). ACQUIRE's ACE Continuum provides a framework for analyzing community engagement in RH/FP and the role the community plays in institutionalizing lasting behavior and social change. The continuum was developed based on a review of documents,[2] best practices, and the lessons learned through the ACQUIRE experience. Global RH/FP service-delivery projects can play a unique role in the understanding of how communities influence sustained behavior change.

[1] The ACQUIRE Project (which stands for Access, Quality, and Use in Reproductive Health) is a five-year global initiative initiated in 2003, supported by the U.S. Agency for International Development (USAID), and managed by EngenderHealth in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa (SWAA).

[2] See the references list at the end of this document.

USAID FROM THE AMERICAN PEOPLE

the ACQUIRE project

The ACE Continuum is a conceptual framework that can be used by other donors, governments, and agencies whose focus is on improving RH/FP systems and services. The continuum can also help with the strategic integration of community engagement into service-delivery projects. The framework provides a basis for discussion related to indicators, time frames, and definitions of terms and is a tool that global RH/FP projects can use to build a shared understanding of community engagement when designing, implementing, and documenting programs.

The continuum consists of three levels of engagement across five characteristics of engagement. The levels of engagement, which move from consultative to cooperative to collaborative, reflect the realities of RH/FP partnerships and programs. These three levels of community engagement can be adapted, with specific RH/FP inputs or activities based on these categories of action. The five characteristics of engagement are community involvement in assessment; access to information; inclusion in decision making; local capacity to advocate to institutions and governing structures; and accountability of institutions to the public. ACQUIRE's experience has shown that community engagement is not a one-time event, but rather is a process, and is an important consideration in the planning and evaluation of programs.

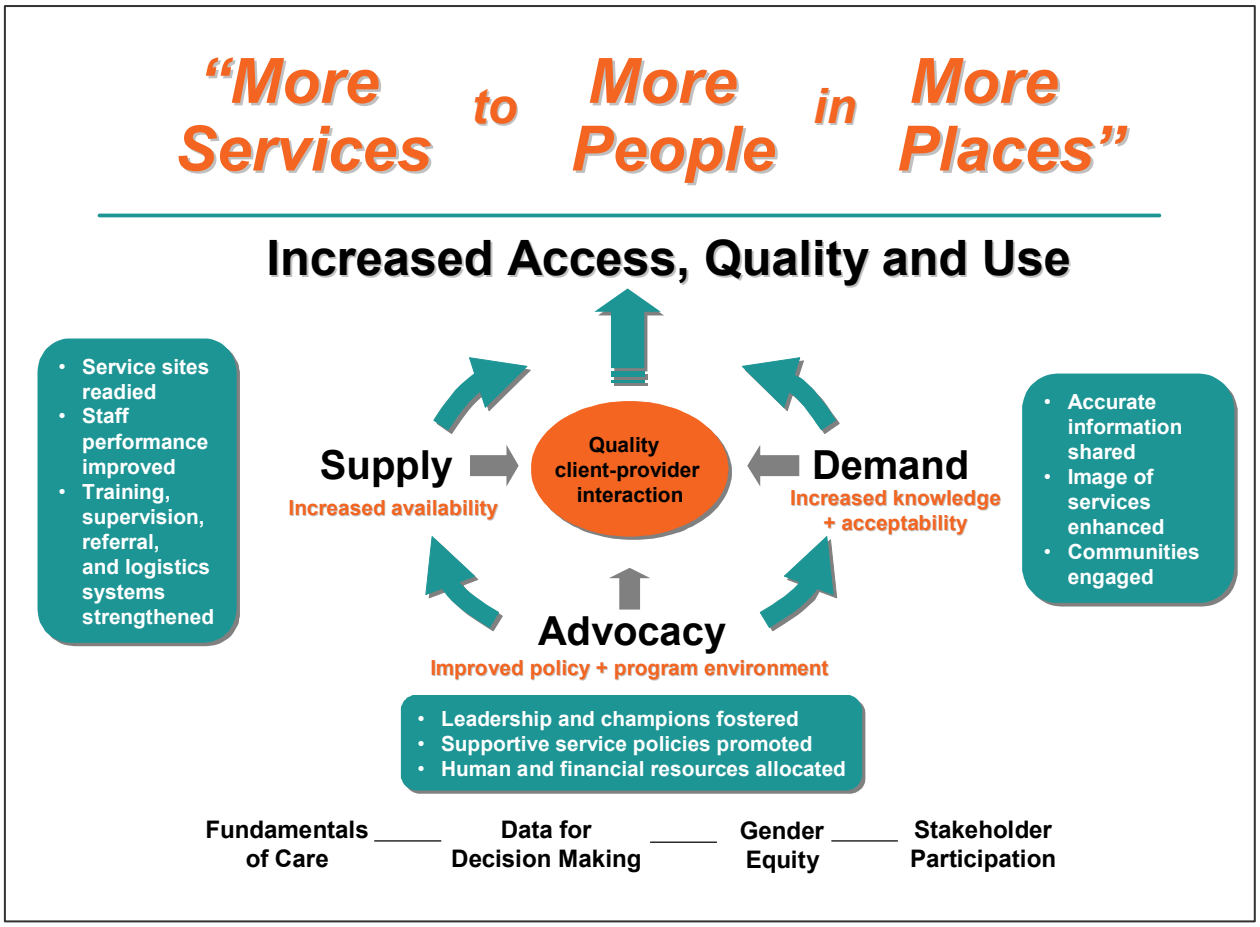
INTRODUCTION

The goal of the ACQUIRE Project is to improve access to and quality and use of FP services. Community engagement is part of the supply-demand-advocacy program model that guides ACQUIRE's work. Community engagement involves a process that includes the sharing of information with stakeholders and the local community. Communities can be reached through media campaigns, representative leaders, or civil society and local community groups. When communities receive correct information, they are empowered to take appropriate action, which generally leads to long-lasting, positive health outcomes (Wallerstein, 2006). It is often challenging to define the communities that should be targeted and to determine how they are to be engaged in global RH/FP projects. The ACQUIRE Project learned that communities can be engaged through a variety of interventions. The more engaged we were in building the capacity of the community to be equal partners, the more empowered communities became. Champions emerged who influenced both individual behavior and social change, resulting in mutual accountability between government and communities for RH/FP services and policies.

The decentralization of government authority to regional and local decision-making bodies fosters increased community engagement. As government agencies, providers, individuals, and groups gain skills and are able to identify and solve problems collectively and advocate for services and policies together, resource distribution becomes more equitable, and institutional transparency and accountability are enhanced. By improving the knowledge of RH issues within the community and by partnering with community members to solve problems, government leaders and public- and private-sector providers can respond efficiently to a community's needs (Wallerstein, 2006). The ACQUIRE Project learned that there are multiple levels of community engagement, and that meeting the needs of all stakeholders requires flexibility by everyone involved, to respond to changes in community needs, political crises, shifts in funding, or other unpredictable changes. As community engagement increases, it is important to incorporate participatory processes (Gryboski et al., 2006) and to encourage the use of tools that develop the capacity of various stakeholders, including community members.

THE ACQUIRE APPROACH

The ACQUIRE Project's goal is to advance the use of facility-based RH/FP services and to strengthen links with communities, to meet the rights and needs of clients. To achieve such a comprehensive goal, ACQUIRE developed a program model (right) linking supply, demand, and advocacy. The supply side represents the need to increase the availability of methods and services, while the demand side includes communications and community engagement, which both respond to and influence the supply side. Advocacy is also key to ensuring increased access to and use of quality services. Underlying all interventions are supportive policies, resource allocation, and gender equity.



The ACQUIRE Project recognizes that behavioral and social change, from the community level to the national level, is necessary to have a sustainable impact on RH/FP. Thus, the ACQUIRE Project has encouraged the integration of all of the components of the supply-demand-advocacy (SDA) approach throughout its program areas.

Community engagement is one component of the SDA approach, and it is a critical aspect of strengthening the rights and needs of communities. The ACQUIRE Project recognizes community members' need for quality RH/FP services and the right (CARE, 2007) to receive them. Existing

political, economic, and cultural structures can be barriers to the public's ability to learn about RH/FP options and services or to participate in the solutions to their RH/FP health needs. At most ACQUIRE Project sites, health infrastructure is poor, and communities are limited by low literacy, gender inequality, and extreme poverty. Community engagement fosters collaboration between individuals, groups, influential leaders, and government agencies. By engaging communities, it is also possible to create a cadre of users of services who are better informed and are better positioned to become partners in their own health care. The ACE Continuum supports the ACQUIRE approach by defining the levels of engagement and their key characteristics of empowerment.

Working with communities is a collaborative process that can be initiated by a local community or by an outside agency, including global, national, or local nongovernmental organizations (NGOs) or government agencies. Ideally, the community engagement process is politically appropriate and culturally sensitive. It is through the inclusion of multiple stakeholders and the empowerment of communities that behavior change can be supported and sustained. The degree of community engagement can fall anywhere along a continuum ranging from passive involvement through public dissemination of information to active community participation in decision making, from the personal to the policy level. The goal of full community engagement is a collaborative partnership among the community, NGOs, and government in which community members serve as champions and advocates for quality programs that take root and are sustained over time. The ACE Continuum can be used to facilitate discussion among program planners and stakeholders to lay the groundwork for indicators that can be used to measure empowerment as well as health outcomes.

COMMUNITY RIGHTS TO DECISION MAKING

The inclusion of community participation in health programs gained global recognition at the Alma-Ata conference in 1978. Since then, there have been debates about the terms used and outcomes expected related to involving communities in health programs (Gryboski et al., 2006). It is most common for RH/FP projects to provide information through media campaigns or community outreach from health facilities. However, other approaches can encourage participation and incorporate dialogue rather than the delivery of messages. These approaches use processes that try to build on traditional beliefs and recognize the contribution that communities can make.

The 1994 Cairo Programme of Action declared that women and men have rights to RH information and services. These rights imply that government health programs have responsibilities to ensure, within their means, adequate access to information and services. Government systems have been decentralized over the past few years, and government processes and resources have become more visible and accessible to communities. They are also increasingly willing to engage community members in the decision-making process around their reproductive health. These rights are often confined to the governments' external projects, and communities themselves continue to struggle to include community members, especially women and other marginalized members, in RH/FP programming.

The World Health Organization (WHO) uses the term "authentic participation" to refer to an empowerment approach that leads to autonomy over decision making by community members (Wallerstein, 2006). This approach is also referred to as a rights-based approach (CARE, 2007) and leads to accountability between communities and other key stakeholders, including policy makers. Service delivery, advocacy, and community engagement are critical to ensuring effective synergy and

mutual accountability between community members and all other RH/FP stakeholders. The ACE Continuum provides a guide to help global partners design projects that respond to the needs of multiple stakeholders (including local communities) without sacrificing the integrity of any partner's area focus.

To improve knowledge of and access to RH/FP services, it is important that external organizations, governments, and projects like ACQUIRE understand the constitution of local communities (CARE, 2007). For the purposes of RH/FP program planning, a community is usually defined by its geographic location in relationship to services. However, one's community identity can vary based on religion, gender, or other affiliations. Community identities, such as gender or faith, can become barriers to participation in RH/FP services as well. Since most such projects are time-bound, facility-based, and focused on health systems, community involvement in decision making may be limited. In these cases, involving communities will be focused on individual decision making around limiting and delaying births through FP planning methods and on satisfaction with services.

There are multiple ways in which communities can be engaged beyond individual decision making related to their choice of FP methods. In communities where rumors and myths often counter the correct RH/FP messages, gaining social support from leaders, family members, and providers is critical to sustaining changed behaviors. In addition, as communities and their members become more engaged, they can assume new and collective roles in decision making around allocating resources, planning programs, defining policies, and ensuring their right to quality services. Ultimately, as community members become more empowered, they will have a more active role in the doctor-patient relationship as well.

PRINCIPLES OF COMMUNITY ENGAGEMENT

Based on the documents reviewed and field experience, the ACQUIRE Project recommends eight principles as a guide for RH/FP service-delivery projects when integrating community engagement into program strategies.

1. **Value partnerships, and their unique contributions, from the global to the community levels.**
   To engage communities, it is often necessary for organizations that work at the global level to partner with national governments, local NGOs, and community-based organizations (CBOs). Each of these partners may have very different missions, but to make the partnership work, each partner needs to value the strengths of the others, finding points of agreement.

2. **Be clear about the purposes and goals of community engagement before starting.**
   All partners must agree on what community engagement means before beginning the project. Understanding the level of engagement and the roles that community members are to play will allow the partners to agree on indicators and on methods for documentation and evaluation.

3. **Define from the beginning such terms as participation, communication, engagement, mobilization, and empowerment as they apply to the project.**
   These terms are often used interchangeably. Indeed, they are very similar. The distinctions between them are small, but it is important that everyone agree to what they mean before starting a project. All of these actions are interrelated and ongoing. Communities are not static, and the community

engagement process is dynamic. Involvement in participatory processes can be time-consuming, and it is important that everyone understand the continuum of participation (Gryboski et al., 2006) as well before starting a program.

4. **Understand that flexibility (of donors, organizations, and communities) is needed to collaborate and share power at all levels of community engagement.**
   Due to the dynamic nature of community engagement, processes and outcomes can change. All partners, including donors, need to be flexible, to adjust to the changes that may occur.

5. **Be willing to determine the level of engagement, including key capacity-building interventions and the time frame, before starting a project.**
   All partners need to agree to these details before beginning a project so that expectations are clear for everyone.

6. **Agree on clear indicators with expected outcomes and on a documentation process that will reflect both RH/FP outcomes and levels of engagement.**
   Some partners may see an empowered community as an outcome in itself. Others will only value a health outcome. When using an engagement process, however, it is important to document both the engagement process and the health outcome.

7. **Expect to engage and then reengage throughout the life of the project, as communities are dynamic and behavior change is not linear.**
   Community engagement is a dynamic process in which leadership and needs are constantly changing. The engagement process is continuous. It can move from level to level or stay at one level, but it constantly must be reevaluated to ensure that indicators are appropriate and met.

8. **Plan the time frame and budget for maintaining community involvement from the start of the project.**
   It is important that time frames match the needs of the desired outcomes and appropriate activities. Budgeting to ensure that the community engagement process lasts the life of the project is important but is sometimes forgotten.

OVERVIEW OF THE ACE CONTINUUM

Levels of Engagement

The ACE Continuum consists of three levels of engagement[3] across five characteristics of engagement. The levels of engagement, which move from consultative to cooperative to collaborative, reflect the realities of RH/FP partnerships and programs. These three levels of community engagement can be adapted, with specific RH/FP inputs or activities based on these categories of action. This framework can be used to develop projected indicators, outputs, and outcomes. Since communities are dynamic, the level of engagement should be evaluated and reassessed periodically.

[3] ACQUIRE chose three levels of engagement, but additional levels could be used—e.g., to reflect a more community-driven approach, in which communities determine their own health issues and do not have to focus on RH/FP issues.

At each level of the ACE Continuum, the ACQUIRE Project has facilitated opportunities for communities to participate in RH/FP services. At Level 1, community engagement is an extension of the service-delivery system, with the focus on outreach from the service center to the community. At each level, community members move from being targets of change to being agents of change as partnership levels increase. Each level of engagement increases with community empowerment. The more informed and involved the community is in all aspects of the development and implementation of a program, the more likely it is that an environment will develop that facilitates a sustained use of RH/FP services (Wallerstein, 2006). By Level 3, communities are more fully represented through civil society, and all stakeholders are mutually accountable.

The levels of community engagement are cumulative, and Level 3 of the ACE Continuum represents a high level of collaboration with the community. To increase collaboration, community empowerment through participation is critical. In designing the ACE Continuum, we relied on the following definition of participation: "…the process that increases a community's capacity to identify and solve problems" (Gryboski et al., 2006). In addition, in the ACE Continuum, empowerment is defined as "a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life" (Rappaport, 1987). External organizations can facilitate the level of collaboration by working with government agencies and others to engage communities in RH/FP programs. Each level of community engagement is valid, and the level of engagement can depend on the program goals, time frames, and budget. The ACE Continuum can help people to plan the intended level of community engagement from the beginning of the process of designing interventions.

Characteristics of Community Engagement

The ACE Continuum is based on five characteristics of empowerment adapted from the World Bank (Naryan, 2002), with input from the U.S. Centers for Disease Control and Prevention (CDC).[4] These are:

1. Inclusion of communities in preprogram assessment
2. Access of communities to information
3. Inclusion of communities in decision making
4. Development of local organizational capacity to make demands on institutions and governing structures
5. Accountability of institutions to the public.

The outputs in each level relate to each characteristic and become a guide for measuring community empowerment at each level of engagement in RH/FP projects such as the ACQUIRE Project.

1. Community Involvement in Assessment

It is assumed that baseline and final evaluation data or findings related to RH/FP services will be gathered for a project. The more that communities are engaged in assessing the health and social factors contributing to the desired RH/FP outcomes, the more relevant the programs will be and the more likely they will be to meet the multiple environmental factors that impact the use of RH/FP services.

[4] The adaptation of the World Bank model benefited greatly from suggestions from Michael T. Hatcher, Chief of the Environmental Medicine and Education Services Branch (and former chair of the Committee for Community Engagement) at the CDC.

The engagement of community members in assessment or evaluation processes often requires partners to be flexible and donors to be open to negotiation (Israel et al. 1998). At the first level, general community meetings are used as a means of consulting community members to refine project design. For example, Community COPE, a tool developed by EngenderHealth, can be initiated by providers as a complement to community meetings to engage community in defining their needs. At Level 2, in addition to such meetings, focus groups can be held to understand more about the communities' perceptions about RH/FP services and related issues. At Level 3, additional participatory approaches can be added that facilitate the identification of social and cultural barriers to accessing RH/FP services. One participatory approach that ACQUIRE has used is the community action cycle, which allows communities to identify their issues, plan and implement actions and evaluate the results.

2. **Community Access to Information**

   At each level of community engagement, the key operative is *equitable* access to accurate information related to RH/FP among men, women, and youth and other marginalized groups. The methodologies for dissemination of this information depend on the communities' level of engagement. At Level 1, communities are engaged only as recipients of information, with the emphasis on the sharing of accurate RH/FP information with the community at large. At Level 2, the communities are included in the dissemination plan for the information. For example, peer educators may be chosen from the community and trained to deliver messages and to facilitate community discussion groups. At Level 3, in addition to receiving and giving information provided by external organizations, a process may be initiated by a local partner organization to stimulate dialogue and discussion about how the information can be assimilated into the local community's cultural and political context. Various theories of behavior change, including the diffusion of innovation theory (Rogers, 1995), tell us how information affects changes in behavior. However, these theories do not address all of the barriers that may prevent people from acting after receiving new information. By Level 3, community engagement is used to move from the passive reception of information to a dialogue that involves all groups (including the marginalized) to address the multiple social and cultural barriers that hinder the sharing and receiving of information.

3. **Inclusion of Communities in Decision Making**

   ACQUIRE's projects are time-bound (often only two years in duration) and often are facility-based, and as a result, community involvement in decision making will be limited. Influential community leaders are sometimes treated as proxies for the community at Level 1 of the continuum. However, they may have their own interests in mind, and their decisions do not always reflect the needs of all community members (Gryboski et al., 2006). At Level 2, mechanisms such as advisory groups are developed, or existing groups are supported. These advisory boards sometimes do not entirely reflect all of the views and opinions of the community, but they can be assessed for gender representation and general reflection of the diversity of the community. By Level 3, civil society groups are included and involved in decision making related to RH/FP programming.

4. **Local Organizational Capacity**

   At Level 1, capacity building is focused on the health service system. As communities become more engaged, they can have new and more collective roles in decision making around resource allocation, program planning, and the definition of policies that affect services. At Level 2, advisory groups' skills are supported so they can oversee the quality of services and facility management.

   Some community engagement processes include facilitated communication processes to allow communities to engage in dialogue and debate about RH/FP issues that help community members

to own their decisions and become agents of change (Gryboski et al., 2006). Involving civil society collectively (versus individually) through community networks and organizations is important if communities are to respond effectively to identified community problems (CDC/ATSDR Committee on Community Engagement. 1997). By Level 3, external organizations are helping to build the capacity of groups to advocate effectively for RH/FP programs and are committed to engaging the community in roles that can affect policy and social change.

5. **Accountability of Institutions to the Public**
   Level 1 is a centralized approach that does not encourage community involvement. By Level 2, there are advisory groups that can interact with government agencies, and by Level 3, input from the community about resource allocation is highly valued. As communities become engaged, power structures become more balanced, and mutual accountability is established. Institutions and communities are informed and understand their roles and responsibilities in assuring peoples' rights to RH/FP information and services. By developing informed community individuals and organizations, institutions will be held accountable for RH/FP-related services and policies. By the same token, informed institutions will accept their role of accountability and will welcome community involvement in monitoring and supporting quality RH/FP services.

The Active Community Engagement (ACE) Continuum

Characteristics of community engagement	Level 1	Level 2	Level 3
Community involvement in assessment	• General information from community meetings used to refine programs.	As in Level 1, plus: • Discussions with leaders regarding reproductive health and family planning (RH/FP) issues.	As at in Levels 1 and 2, plus: • Participatory exploration of community power relationships and social context
Access to information	• Accurate RH/FP messages disseminated through media and government structures.	As in Level l, plus: • Community agents disseminate messages with limited interpersonal interaction.	As at Levels 1and 2, plus: • Community agents facilitate dialogue on FP/RH and its relevance to daily life.
Inclusion in decision making	• Input/approval solicited from influential community leaders at start of project	As in Level 1, plus: • Leaders and advisory groups involved as ongoing partners in decision-making.	• As in Levels 1 and 2, plus: • Community-based organizations (CBOs) and groups collaborate in decision making.
Local capacity to advocate to institutions and governing structures	• Strengthen FP service delivery through community outreach (info, services).	As in Level 1, plus: • Build capacity of local leadership and advisory groups to oversee quality of RH/FP services.	As in Levels 1 and 2, plus: • Build capacity of CBOs and foster organizational linkages to advocate for quality RH/FP services and policies.
Accountability of institutions to the public	• Health services/policies informed by providers and governments with limited community input.	As in Level 1, plus: • Health services/policies have systems for citizen participation (e.g., health advisory groups).	As in Levels 1 and 2, plus: • Health services/policies ensure equitable input from community to inform RH/FP resource allocation.

COMMUNITY ENGAGEMENT LESSONS LEARNED

- Each level of engagement implies some commitment to building the capacity of communities in decision making related to RH/FP services and policies.
- As community engagement through collaboration increases, there is more power-sharing and less control remaining with the external organization or other agencies outside of the community.
- Champions can be important to ensuring the sustainability of RH/FP services and policies. Community, provider, government, and other champions should be identified, publicly promoted, and supported through appropriate technical support.
- Flexibility is required, since expected outcomes might not occur within the time allotted for the project. In some cases, empowerment outcomes may emerge before desired health outcomes.
- New documentation strategies that include qualitative methodologies rather than quantitative approaches may be required.
- It is important to form and maintain partnerships globally, nationally, and locally when engaging communities for RH/FP services.
- Each partner has different expectations of what their roles should be. Adopting shared language and expectations is critical.
- The ACE Continuum facilitates discussion that can lead to agreement over terms and to a level of community engagement that will satisfy all of the partners.
- It may be necessary to facilitate trainings of global, national, and community-based staff to build an understanding of terms, goals, and time frames. Many participatory tools can assist in engaging communities at the local level (CARE, 2007).
- One project could incorporate all three levels of engagement at one time, depending on the focus of the activity. A project may incorporate a Level 1 effort for information but may work at Level 3 for assessment. These levels can also change through the life of the project. For example, if a project is funded for two years and is focused on increasing the use of IUDs, the partnership may agree that a Level 1 approach is most appropriate for an information strategy, with some use of peer educators to reach out to the community. There is minimal community capacity building. However, the partners may agree to Level 2 documentation approaches, which would include qualitative methods to document the peer educators' interfacing with providers and their use of the information, education, and communication materials. Case studies or stories could incorporate some creative community engagement methodologies.
- Partner flexibility and compromise that does not threaten the integrity of any partner is essential to the integration of community engagement into any RH/FP project.

MOVING FORWARD—DISCUSSION

Although there is a long history (beginning with Alma Ata in 1978 and extending to the Cairo conference in 1994) of recognition that community participation is integral to positive health outcomes, there is still disagreement about when and how to engage the community. Under the ACQUIRE Project, we learned that there is no right or wrong way, but that multiple ways to engage the community are needed. It is a dynamic process, and one program could reach multiple levels of

engagement at different points in the program. The experience from ACQUIRE has shown that community engagement is not a one-time event, but rather is a process that may vary depending on the definitions of community and the types of interventions. The communication process becomes less vertical, with communication based on dialogue rather than messages. The more horizontal the process is, the more the community is empowered to own the process (Howard-Grabman & Snetro, 2003). Although it is the health outcome that is of most interest to RH/FP programs, there is evidence that empowerment relates to health outcomes. Therefore, community engagement is important to consider in planning and evaluating programs.

RH/FP programs have an opportunity to begin to define terminology and merge behavior and social change methodologies and other continuums to begin to define indicators that capture both empowerment and RH/FP outcomes. In a time of reduced resources for family planning and of decentralization of services, this offers an opportunity to engage communities and expand networks of stakeholders.

CONCLUSION

The ACQUIRE Project developed the ACE Continuum to provide a framework for defining community engagement to help global RH/FP projects design activities that fit within the context of their projects. The ACE Continuum can also be a tool for global RH/FP projects to use in negotiating community engagement programs and activities with donors, governments, and other partners.

In projects where health outcomes are the goal, community engagement often occurs through community outreach by community-based distribution staff, volunteers, or mobile services. Programs or organizations that use a rights-based approach and include community empowerment goals may gauge program success based on empowerment indicators. The ACQUIRE Project has learned that dual impact is possible and that appropriate indicators reflecting both community engagement and improved RH/FP are important.

The ACE Continuum recognizes the variety of levels of community engagement for RH/FP service delivery. When community empowerment is seen as an outcome along with improved access to quality services, an increased commitment of time and other resources by stakeholders and donors is required. External projects like ACQUIRE can be a catalyst for community engagement. Facility-based FP programs can be enhanced and sustained through increased community engagement.

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