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TRAVAILLER AVEC LES COMMUNAUTÉS

WORKING WITH COMMUNITIES

TRABAJAR CON LAS COMUNIDADES

EN

WORKING WITH COMMUNITIES

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WORKING WITH **COMMUNITIES**

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INTRODUCTION

There is a growing gulf between aid workers and the populations they assist. Several factors contribute to this: transformations in humanitarian aid, the increasing size of programmes and the means allocated to them (4WDs, sat phones, guards, etc.), along with the turnover of expatriate staff. As projects become ever more technical and caught up in their plethora of procedures, they increasingly exclude non-professionals and demote the populations to the status of mere "users".

The issue does not boil down to aid workers save lives and victims are saved. Humanitarian workers also need to accomplish the mission they are assigned within given timeframes and deal with issues of professional standing and positioning within an organisation. The "victims" too want to work alongside those that are helping them to acquire social standing or to fight injustice. And so they become entangled in an imbalanced aid relationship that sociologist Marcel Mauss characterises by **a lack of a system of gift/counter gift:** "The gift not yet repaid debases the man who accepted it, particularly if he did so without thought of return […] To accept without returning or repaying more is to face subordination, to become a client and subservient".[1] This is further aggravated by the vocabulary used as we speak of "beneficiaries", "victims" or, even worse, "targets"! Humanitarian emergency aid nowadays requires major, costly logistics to be deployed and so reflects the imbalanced image of the saviour figure of the aid worker against that of the victim or disaster survivor. This also calls to mind the words of anthropologist Adorno: "Charity is necessarily accompanied by humiliation through its distribution, its just allocation, in short through treatment of the recipient as an object […]".[2]

One of the key words to reduce this imbalance and to start viewing the people themselves as part of the response to their own problems is **participation;** this should ensure they are no longer simply "recipients" but recognised for what they can contribute to their community. However, this approach, recommended by the Ottawa Charter for Health Promotion (1986), obviously calls into question the powers of the actors and the relationships they build with the populations they are helping. Organisations struggle to position themselves and find their "rightful place" in the eyes of the population.

Many of Médecins du Monde's projects nowadays have developed a **community approach** and involve various representatives from the population: peer support workers, community health workers, traditional healers, religious leaders, etc. It is based on the idea that the population's involvement helps not only to improve the quality of programmes, by providing a more precise analysis of the situation and context, but also recognises the right of these populations to self-determination. Participatory actions are therefore part of defending patients' rights and access for all to social rights. They also allow actors to reach out to the people and initiate a dialogue on managing their own health.

Public involvement also helps to offset the fact that medical responses fail to fully meet health needs. It can thus also be seen as essential to compensate for a failing health system.

However, sometimes we have the impression that projects underestimate the extent to which the process is difficult and unstable, in particular the divides that can be encountered in what is known as the **community**. Working with people from a community requires us to already have an idea of what makes up a community and how it works. Community participation is complex and throws up many obstacles: lack of time to consult with people we would like to involve, particularly in emergency situations; misunderstandings over the meaning of the words "community" and "participation"; lack of mutual understanding of socio-cultural representations, knowledge, practices, language, history, etc. All these inevitably influence the way in which actors and populations interact.

These guidelines aim to help us understand what we mean by "working with communities and "community participation" and identify the obstacles and stakes for community participation so that future projects are better adapted to the realities of the populations concerned. We have deliberately chosen not to go over all the concepts and literature produced on community health but to retain only the socio-cultural angle by providing keys for cultural understanding and methodological bridges.

The guidelines are based on several works and field practices and on the wealth of information gathered during the discussions on these issues at the international workshop in 2010 in Nepal.[3]

It offers a range of definitions, crucial for ensuring that we are all speaking the same language and are on the same page.
It discusses the history behind the emergence of the different concepts of community action.
It also constitutes a critical perspective of these concepts and practices, an absolute necessity for any professional approach.
And lastly, it puts forward concrete examples of community practices and actions, with a methodology to facilitate socio-cultural analysis and project design.

1. M. Mauss, *The Gift in Sociologie et anthropologie* [Sociology and anthropology], PUF 1985, p. 258 and 270.
2. T. W. Adorno, *Minima Moralia,* PUF 1983, p.39.

3. This "Working with Communities" workshop met from 27th September 2010 to 1st October 2010, in Dhulikel, Nepal, and brought together around fifty people from different countries (Afghanistan, Indonesia, Nepal, Pakistan, Vietnam, Colombia, Madagascar, Niger, Myanmar, India, France), Médecins du Monde staff and local partners. The aim was to improve Médecins du Monde's practices through better consideration of socio-cultural diversity in drafting and implementing various projects.

NB

These guidelines are not a comprehensive methodology manual and it is important to refer to other guidelines such as:

- → *Data Collection, Qualitative Methods,* MdM, 2009, 2nd edition 2012;
- → *Pour une éthique de terrain. Gestion des données personnelles sensibles (Santé - Histoires de vie)* MdM, 2010, [Field Ethics. Management of sensitive personal data (Health – Life Stories)];
- → *Guide de planification de projet de santé, [Guide to health project planning],* MdM, available in 2012.

1. THE FUNDAMENTALS OF COMMUNITY APPROACHES

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1A CURRENT DEFINITIONS

Community development, community health, community action

Since the Alma-Ata conference in 1978, the concepts of **community development, community health, and community action for heath** have been popularised and have remained closely linked to the **concept of health for all.** Here is a review of the definitions:

COMMUNITY DEVELOPMENT

According to the United Nations,[4] community development is: “the processes by which the efforts of the people themselves are united with those of governmental authorities to improve economic, social and cultural conditions of communities. [...] These processes assume the participation of the people themselves in efforts to improve their standard of living, with as much reliance as possible on their own initiative; and the provision of technical and other services in ways which encourage initiative, self-help and mutual help, and make these more effective. [...] Development programmes involve local communities, given that the people who live in the same locality have numerous interests in common”.

COMMUNITY HEALTH

Amongst the many definitions we will take that of the World Health Organisation (WHO), which states that community health is the “process by which individuals and families take charge of their own health and well-being as well as that of the community and develop their capacity to contribute to their own development as well as that of the community”.

Note that in this definition, the term “community” refers to a population whose members, aware that they belong to a same group, have by definition common interests. Therefore, we can talk of community health when the members of a geographical or social community consider their health problems together, express their most important needs and take an active role in introducing, rolling out and evaluating the most appropriate courses of action.

4. United Nations definition, 1961.

COMMUNITY ACTION FOR HEALTH[5]

"Community action for health refers to collective efforts by communities which are directed towards increasing community control over the determinants of health, and thereby improving health" The important concept to remember here is "taking ownership" of a problem or action undertaken previously.

PUBLIC HEALTH

The WHO defines public health as "the science and art of preventing disease, prolonging life and promoting mental and physical health and efficiency through organised community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organisation of medical and nursing services for the early diagnosis and preventive treatment of disease and the development of social mechanisms to ensure to every individual a standard of living adequate for the maintenance of health, so organising these benefits as to enable every citizen to realise his birth right of health and longevity." [6]

So the WHO definition presents public health as a means for society to defend itself against the disorders that threaten it. It refers to a proactive and multidisciplinary approach to health issues related to human collectivities.

Comparing public health and community health[7]

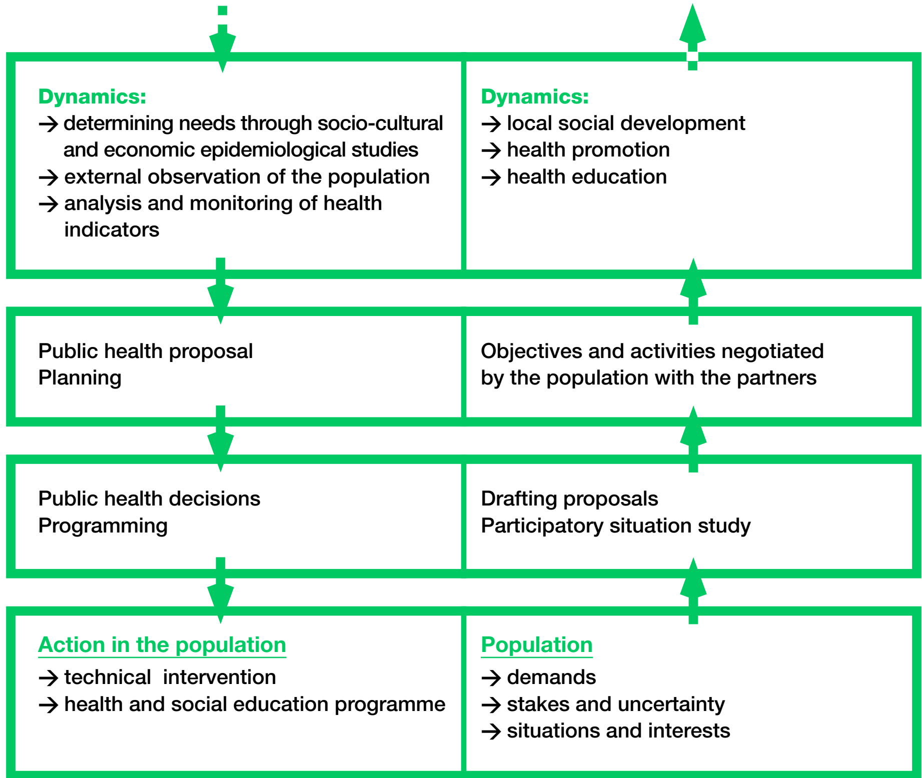
COMPARING DEFINITIONS

Public health is a collective and administrative approach to a population's health problems in its political, economic, regulatory and institutional aspects.
Community health is a local approach to a community's health problems implying its active participation at all stages.

Public health is defined and implemented by the relevant authorities for the benefit of a population by means of health policies.
Community health is in theory implemented by a group of professional actors and the population.

COMPARED APPROACHES[8]

Public health: a top-down approach	Community health: a bottom-up approach



Dynamics: → determining needs through socio-cultural and economic epidemiological studies → external observation of the population → analysis and monitoring of health indicators	**Dynamics:** → local social development → health promotion → health education
Public health proposal Planning	Objectives and activities negotiated by the population with the partners
Public health decisions Programming	Drafting proposals Participatory situation study
Action in the population → technical intervention → health and social education programme	**Population** → demands → stakes and uncertainty → situations and interests

5. **WHO,** Glossary of health promotion, 1999, Geneva.
6. **J. Hogarth,** "Public Health Vocabulary", WHO, 1977.
7. **S. Tessier, J.B. Andreys, M.A. Ribeiro,** *Public health and community health,* Maloine, 1996.
8. Table by **J.L Veret** (modified by B. Goudet), "Glossaire de l'Éducation et la promotion de la santé : contribution à l'élaboration d'un langage commun", [Glossary of Education and Health Promotion: contributing to a common language], Cores, 2002.

These comparisons highlight two specific rationales, the community approach being markedly different from the public health rationale.

"Community", "participation" and "community participation"

The words "community and "participation" are used with such diverse meanings that they need to be clarified. Below are the usual definitions; later in the guide we will review the concepts of **community** and **community participation** in all their complexity and polysemy.[9]

DEFINITIONS OF COMMUNITY[10]

The term community is characterised by its variety of meanings:
→ group of people living together in a specific geographic area;
→ set of individuals who share ethnic traits, values, culture, possibly religion;
→ members with common property;
→ group with common interests;
→ members of the same discipline;
→ people sharing the same objectives;
→ (ecology) group of interdependent organisms occupying the same region and interacting with each other.

9. Characteristic of having multiple content and several meanings.
10. Based on a compilation from a literature review.

Anthropological definitions of: social group, community/society, clan, tribe and ethnic group

NB: these concepts are complex and their definitions can vary from one decade to the next, one school of thought to the next and sometimes from one researcher to another…

The group and the social group

A group is just a gathering of people. The notion of a social group is more complex. Indeed, not all gatherings of people are necessarily a social group: a queue in a shop, simple proximity of individuals, etc. does not constitute a social group. Being in the same place at the same time does not automatically create a social link. Furthermore, groupings of people who have things in common do not necessarily form a social group; they can be categories (specific socio-professional categories, teachers for example). To have a social group, there must be one or several links between the people making up the group: adherence to certain norms and values (faith group), participation in an activity (work group), etc. Groups can be classified according to their size, their constitution, their functions, their duration, etc. The sense of belonging, the group conscience and attachment to specific group symbols can be characteristic of the social bond. The group exists if there are direct relationships established between its members and if they communicate amongst themselves. There is a marked difference between what is within the group and what is external to it: between "us" and "them".

Society, institution

A society is an extended social group, an assembly of several social groups that coexist, but do not necessarily have direct links. In order to have a society, the groups need to share common values, norms and representations, whether imposed or chosen. A society is regulated by its institutions.

An institution is a way of thinking and acting collectively, a series of rules between people and practices. An institution is a social structure regulating relations between people. Marriage, for example, is an institution.

Community and society: *Gemeinschaft* and *Gesellschaft*

The German sociologist Ferdinand Tonnies[11] opposes these two terms. *Gemeinschaft* means "community" and *Gesellschaft* is "society". According to him, there was a shift from *Gemeinschaft* to *Gesellschaft* when societies became more complex; for example when moving from the social, more personal, organisation of the village to a more regulated urban one. In Gemeinschaft, the majority of people know each other; relationships are more personal than in the anonymity of the big city.[12] However, this rather perfunctory opposition comes up short as it erases the complex characteristics of communities that link together heterogeneous populations in terms of their attitudes and feelings. Community links are often associated with strategic situations, conflicts, violence, etc.

We will retain, for simplicity's sake, the ethnology and anthropology dictionary definition[13] given under community: "Whatever the importance of the concept of territory, community finds the principle of its existence in history. This connection with time is expressed through blood ties, consanguinity (birth determines membership of a community) and culture that is perpetuated, reflecting the durability of this community".

Clan, tribe, ethnicity

A clan is a group of individuals interrelated by kinship: its members are descendants of the same ancestors. It includes the notion of consanguinity, blood ties, as opposed to land ties. Kinship therefore plays a crucial role in this concept. But the clan ancestors are generally so distant that the living descendants are unable to fully trace their family tree that far back. Moreover, this ancestor is often a mythic being endowed with supernatural powers.

As Marcel Mauss stated in 1937, clan members recognise each other by their name, crest or totem. Each individual must know the name of his/her clan. A clan-based system is linked to a static culture and being more or less settled in one area, depending on how sedentary the lifestyle is. Such conditions are to be found in rural societies, where mobility is limited; a person is born, lives and dies in the same village surrounded by the same neighbours. Belonging to a clan brings with it internal demands for social solidarity, mutual assistance and even participating in ceremonies. Close 15to which we belong by birth provides security and a sense of worth, crucial for an individual in this kind of society. This is very different, for example, in industrialised societies where an individual can get ahead faster alone than as an individual member of a kinship group. This supposes that security can be assured independently of the clan.
The clan also has a political unit and is likely to form associations with other clans to create a tribe. **A tribe** is in fact a much larger group than a clan. Tribal ancestry lies in the distant past, along with the origins of Man (almost a god), predating the clan ancestors.

An ethnic group and a tribe are often interchangeable in everyday parlance. Max Weber calls "ethnic groups" those human groups that demonstrate a subjective belief in their common ascendance because of physical similarities or customs, or because of shared memories of colonisation and migration. For him, the sense of ethnic belonging (*Gemeinsamkeit*) differs from belonging to a kinship group because its identity is presumed and does not constitute a group as such. What is important is the sense of belonging, insofar as individuals use ethnic identities to classify themselves and others. They therefore form ethnic groups in the organisational sense of the term. Common criteria used to define ethnicity are: language, location, culture, customs, values, a name, a common ancestry and an awareness that the individuals belong to a same group.

That said, there are dangers and limitations in using this concept, as it paves the way for analysing interactions between ethnic groups as power relations. Each group should be seen as the result of a network of relationships. Rather than perceiving ethnic frontiers as being geographic borders, they should be

11. F. Tonnies, *Community and society,* Retz, 1977.
12. This should be qualified as there are neighbourhoods in big cities with a social organisation close to Gemeinschaft.
13. P. Bonte and M. Izard, *Dictionnaire de l'ethnologie et de l'anthropologie* [dictionary of ethnology and anthropology], PUF, 2000.

viewed as semantic boundaries, or those of class systems and social categories. It is a constructed identity consistent with notions of clan or of tribe. According to Fredrik Barth,[14] there are no culturally and linguistically homogeneous ethnic groups; these societies are unequal and heterogeneous. Social and geographic distances lend a sense of "purity" and homogeneity to a heterogeneous and hierarchal environment.

Participation[15]

Participation is the fact of being involved; that is to play one's part at a personal level, both in thought and deed.

Community participation

According to WHO[16] community participation is a means leading to better organisation of health services and/or a condition for improving populations' health. (This key concept will be further developed later)

14. F. Barth, *Ethnic Groups and Boundarie: the Social Organisation of Culture Difference,* Universitets Forlaget, Bergen, Oslo, George Allen & Unwin, London 1969.

15. J.L Véret, "Glossaire de l'éducation et la promotion de la santé : contribution à l'élaboration d'un langage commun", [Glossary of Education and Health Promotion: contributing to a common language], Cores, 2002.

16. WHO, Alma-Ata Declaration, 1978; Aims of Health for All by the year 2000, Ottawa Charter 1986.

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THE ORIGINS OF THE COMMUNITY APPROACH: HISTORY, KEY DATES AND CONTEXT

The concept of community health stems from a series of reflections, drawing on a range of disciplines: epidemiology, law, biomedical and human sciences, such as sociology, anthropology, educational sciences and communication sciences. It is also linked to socio-political and economic contexts and even to the state of advancement of science and technology at a particular time, which only a historical perspective can help us to understand.

From epidemiology to public health

The first major French epidemiological surveys carried out by Villermé and Buret[17] around 1840, were pioneers in bringing to the fore public health issues and the responsibility of social organisations. They established striking correlations between the living and working conditions of the working class and the high morbidity amongst these populations. Then, at the end of the 19th century, the fight against tuberculosis, a disease that afflicted the young, pushed forward efforts on this agenda. The League against tuberculosis was founded in 1892 and 1901 saw the creation of a society of philanthropic and social inspiration for the prevention of tuberculosis through public education. A short time later, as part of the American war effort (1917-1918) and up

17. Villermé studies (1840): "Tableau de l'état physique et moral des ouvriers dans les fabriques de coton, de laine et de soie" [table of the physical and moral state of workers in the cotton, wool and silk factories], and **Buret** (1839): "De la misère des classes laborieuses en France et en Angleterre" [poverty amongst the working classes in France and England].

to 1923, the Rockefeller foundation developed popular education programmes using mobile teams crisscrossing the countryside handing out brochures, giving talks and organising film shows.

Social hygiene and health education

In 1941, a period of decline during the Second World War, regional health education centres were set up in France, the forerunners to today's "health education committees". In addition to the creation of the mother-child protection scheme (MCP), 1942 saw the introduction of the review *La santé de l'homme* [Men's Health]. This review, still published under the aegis of the National Institute for Prevention and Health Education (INPES), included articles with a hygiene and humanist approach to the health of the different categories of the population. The topics most often addressed were alcohol, tobacco, and personal and food hygiene. 1945 was, of course, the year the Social Security system was launched, but it was also the year that the National Centre for Health, Demographic and Social education was set up. Medical students interested in public health visited schools to pass on health prevention messages to pupils. And, in 1946, an employer-funded system of occupational medicine with a preventive remit was introduced.

From the 1950s, however, public health prevention lost ground for two reasons:

- → economic growth: as poverty lessened, the capacity of the individual to access healthcare system increased,
- → major advances in medical technology: this was the era of developing drug efficacy, especially with the mass availability of antibiotics (decline of tuberculosis) and vaccines.

This twofold progress pushed the "social issue" into the background along with the question of prevention: what was the point in prevention when science could cure everything! At best, social issues only involved specific and more vulnerable populations such as immigrant groups and travellers to help them access their social rights.

Nevertheless, an element of the medical fraternity raised certain questions regarding science and technology's invasion of medicine, while health social inequalities had not disappeared. Moreover, even though western countries had started to shake free of the major epidemics, was it acceptable that southern countries did not enjoy the same good fortune? These ideological issues inspired health professionals to develop alternative or humanitarian initiatives.

From a collective consciousness to community health

New issues emerged to cause concern to healthcare actors arising from changes in health and social medicine such as the morbidity and mortality linked to clandestine abortions or inequitable access to healthcare. Actors and campaigners, influenced by the prevailing ideologies of their time in intellectual circles, adopted two directions:

Support for the moral liberation struggle: firstly for the "happy motherhood movement", nowadays better known under the name of family planning, and also the movement for freedom of access to abortion and contraception. The first is above all a network of associations working both as action centres and pressure groups. This network contributed to the drafting of the Neuwirth Law (1967) that led to the foundation of education and family planning centres. The second movement, supported by young professionals and feminist movements, resulted in the 1975 Veil Law on abortion.

Community health measures and the development of health centres. These initiatives aimed to bring health professionals closer to the population as well as to engender changes in relations between practitioners and patients, involving individuals in their own healthcare decisions. In the 1960s, the introduction of health centres was seen as an alternative to private medical practice. The main aim of these health centres was to dispense quality healthcare in underprivileged areas far from health facilities, by providing free access to care regardless of the patient's resources or place of residence. These centres reflected a good understanding of the economic and social environment.

At the same time, the National Centre for Health and Social Education became the French Committee for Health Education (CFES) in 1972. It was made responsible for rolling out large scale media campaigns with educational messages targeting different audiences with specific problems such as: alcoholism, diabetes, nicotine addiction, drug addiction and cardio vascular disease, etc.

Combating HIV/AIDS and support groups

The medical world's sense of disarray and powerlessness in the face of HIV/AIDS discovered in 1983, as well as its specific transmission modes, triggered an unprecedented movement to combat the disease, and provide support and prevention. This movement was mainly initiated by volunteer activists, mobilised and organised around the gay community, focusing on those infected as well as their close friends and relatives. Many were heirs to the sexual revolution of the 1960s and 1970s and for the right to abortion. Among the successes of this movement were the creation of Aides in 1984, Arcat-SIDA in 1985 and Act Up-Paris in 1988.

The 1980s: the WHO approach, community health centres and health promotion[18]

This period saw major progress in community health practices in the Anglosphere, Quebec and Latin-American countries. These practices enjoyed some success and presented an alternative for structuring health systems, especially in developing countries.

In 1978, the international Alma-Ata Conference on primary healthcare, a WHO priority, published a declaration setting out the main strategic and methodological milestones for a community health approach. This declaration established the basis for a health system: primary healthcare delivered at the local level by medical staff working as promoters of health practices and actively involving the population. The "health centre", as defined by the WHO, is a facility providing medicosanitary services to a given community. It works on disease prevention and promoting the health of individuals, families, specific groups and the community as a whole. It must also provide medical care. In 1986, the international Ottawa Conference drafted a health promotion charter, drawing on concepts of social medicine and community health.

Ecological approach: the seven WHO major health determinants[19]

According to the WHO, the aim of "Health for All" is to ensure that all citizens achieve a standard of health that allows them to lead socially and economically productive lives. The basic premise for improving health is to act on three main fronts: lifestyle, environment

18. B. Goudet, *op. cit.*
19. WHO, Health promotion glossary, Geneva, 1999.

and healthcare. In an ecological approach, the social model thus takes precedence over the medical one. The risk factors determining an individual's health status are replaced by health determinants that can be defined as **the personal, social, economic and environmental factors determining the health status of individuals or populations.** The factors influencing health are many and varied and interact with each other.

This social model comprises seven major health determinants identified by the WHO: peace, water and healthy food, housing, income, education, recreation and healthcare. The legal dimension of health (political, economic, social and cultural rights) is not yet included. Yet, this is a factor since lack of basic rights poses a health risk.

SOME KEY DATES IN HEALTH PROMOTION

1978: The Alma-Ata Declaration (WHO)

In 1978, the international Alma-Ata Conference on primary healthcare, organised by the WHO, brought to the fore the concept of participation, which it defined as a determining factor in community health action. In particular, the Alma-Ata Declaration stated, "people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare" (WHO, 1978). Although the conference stressed the need for organised primary healthcare, the recommendations firmly promoted self-responsibility for the community and the individual, and their involvement in planning, organising, running and supervising primary healthcare.

1986: the Ottawa Charter (WHO)

Eight years on, a new international conference in Ottawa adopted a charter on health promotion that defined it as "the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or adapt to the environment. Health is, therefore, seen as a resource for everyday life, not as the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not the responsibility of the health sector alone as it goes beyond healthy life-styles to aim at well-being."

According to the WHO, the prerequisites for health are: peace, shelter, food and an income. Working in health promotion therefore means:

→ Drafting a sound public policy.
→ Creating positive environments (socio-ecological approach to health): it should be noted that living, working and recreational conditions are seen as a source of health and health promotion is seen as a means for making these conditions healthier.
→ Strengthening community actions: "Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health".
→ Developing personal skills: "Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health".
→ Reshaping health services: "The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a healthcare system that serves the pursuit of health. The role of the health sector must move increasingly towards health promotion, beyond its responsibility for providing clinical and curative services".

1997: the Jakarta Declaration (WHO)

The Jakarta Declaration stipulates that health promotion is "a practical approach to achieving greater equity in health". It identifies five priorities for health promotion[20]: promote social responsibility for health; increase investments for health development; consolidate and expand partnerships for health; increase community capacity and empower the individual; secure an infrastructure for health promotion. To achieve these priorities, the Jakarta conference set itself the challenge of involving, alongside the usual health promotion specialists, "new players in health promotion, […] all individuals, bodies and institutions who directly or indirectly influence a population and who up until now have not been involved in health promotion". The aim is to move towards a "global alliance of health promotion".[21]

1998: Global Health Declaration (WHO)

"[…] changes in the world health situation require that we give effect to the "Health-for-All Policy for the 21st century" through relevant regional and international policies and strategies. […] We, the Member States of the WHO, hereby resolve to promote and support the rights and principles, action and responsibilities enunciated in this Declaration […] and we call on all peoples and institutions to share the vision of health for all in the 21st century, and to endeavour in common to realize it."

1998: World conference in Puerto Rico (IUHPE)

The International Union for Health Promotion and Education (IUHPE) was mandated, in light of globalisation, to intercede with the World Trade Organisation (WTO) during the trade liberalisation negotiations. In particular, it was stated that the inequalities in access to resources and the gap between rich and poor explained the major differences in a population's health status. It was also recalled that the public health policy strategy set out in the Ottawa Charter, which should be applied to economic determinants, should also be implemented.

2005: The Bangkok Charter (WHO)

The Bangkok Charter sought to review and expand on the values, principles and action strategies set out in the Ottawa Charter and previous conferences. Above all, it examined the concerns raised at the Jakarta and Puerto Rico conferences, which focused on promoting the means deployed in support of the political and economic "determinants" of health. It aimed to enable the health promotion strategy to be acted upon in a world of ultraliberal globalisation. For the most part, the measures related to governments, intergovernmental agreements, administrations and public bodies as well as the business sector.

20. Refer to the declaration on the WHO website, www.who.int.
21. M.C Lamarre, *La santé de l'homme,* [Men's Health] no. 325, 1996.

MdM has observed in its different projects a wide variety of issues with community components, from reproductive health to harm reduction, mobile clinics, microcredit, primary healthcare, HIV/AIDS prevention, advocacy, etc. Similarly, we have seen a rich heterogeneity among the community stakeholders: alongside community health workers, we find peer educators, village health committees, religious leaders and women elders. This is all a consequence but also a source of a variety of images and expectations with regard to supposedly common concepts: community, participation – which are far from being shared as we saw during the workshop discussions in Dhulikel.

2. CHALLENGES, BENEFITS AND LIMITATIONS OF COMMUNITY APPROACHES

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THE CHALLENGES OF COMMUNITY APPROACHES

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34 The challenge of apprehension and comprehension of needs that are not always expressed
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2B

THE COMPLEX NATURE OF **WORKING WITH COMMUNITIES**

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55 **4/ Partnership and network issues**

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2C

COMMUNITY WORKERS (COMMUNITY HEALTH WORKERS, INTERMEDIARIES, RESOURCE PEOPLE, ETC.)

62 **1/ Diversity of functions and designations**

62 **2/ Socio-cultural proximity (social position, status within the group, language, etc.) as common criteria for selecting community health workers.**

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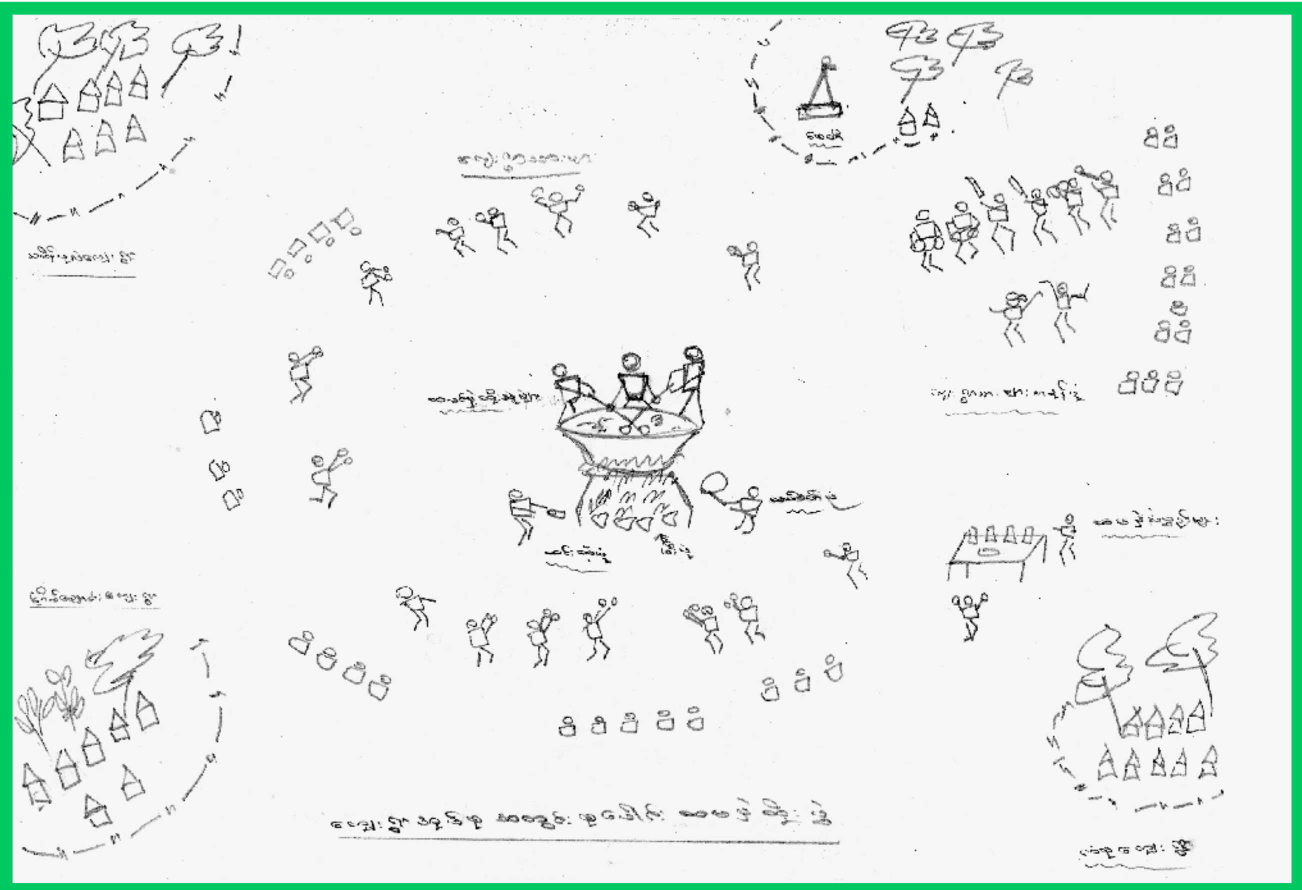
74 **7/ Roles apart: peer educators and traditional health practitioners**
74 Peer educators
75 Traditional healers
76 Traditional birth attendants

The community seen by Myanmar's national team: the traditional meal celebrating the end of the harvest season.



The community seen by a Dutch international staff member: three community levels – family, friends and work – are represented in the fore-, middle- and background. A satellite in the sky represents the virtual community.

The community seen by a national staff member working on the India project in Jaipur: a representation of a group of people who are different, but who share the same place and the resources available. The elephant symbolises the community's cultural and economic heritage.

The community seen by beneficiaries of the India project in Jaipur: for people living in slums, belonging to a community means living in a house with a roof and other comforts. Here we can see a chimney, a drainage system and a paved path.

CHALLENGES, BENEFITS AND LIMITATIONS OF COMMUNITY APPROACHES: SAME WORDS BUT DIFFERENT REPRESENTATIONS, CONCEPTS AND STRATEGIES

Community approaches arise from a whole range of initiatives guided by numerous trends in ideas, ideologies and utopias. Their initiators, stakeholders determined to bring about change and transformation, have gradually expanded their knowledge of these approaches through experience. The contribution of pluridisciplinary knowledge can bring a critical perspective to the actions, methodological tools and techniques that they have developed. With this in mind, this second part presents a series of sociological and anthropological contributions to help gain an understanding of the issues, benefits and limitations of community approaches.

2A THE CHALLENGES OF COMMUNITY APPROACHES

A whole host of projects, stakeholders and strategies, all faced with the same challenges: how to create a process that produces shared benefits and solutions, and acquire new skills for humanitarian actors and populations alike.

1 / THE CHALLENGES FOR AID AND DEVELOPMENT ACTORS

The challenge of efficiency/effectiveness[22] and the local level

The first challenge for aid and development actors is to make aid more efficient, more effective and more pertinent to be able to better adapt it to the real needs of populations and their circumstances and avoid the ethnocentric position often unconsciously adopted by workers "from elsewhere". And, while working with communities obviously increases the resources available for a project, the number of people, for example, it also improves access for the most isolated of populations. The importance of the local level in the organisation of health systems has continued to grow since the Alma-Ata Conference. Today, community action is encouraged in local health management by, among others, the participation of community representatives in health committees.

With this in view, three major principles stand out for the deployment of community health activities:

22. Effectiveness is the extent to which the objectives of a project are reached or are in the process of being so. Efficiency is the extent to which a project's material, human and financial resources (funds, expertise, time, etc.) are converted into results.

1 / **The principle of proximity and simplicity:** reduce obstacles to access to healthcare and facilitate administrative, economic and geographic access to prevention and treatment. This implies taking services and workers closer to the places where the populations live and simplifying administrative and financial procedures to facilitate access to healthcare as much as possible.

2 / **The principle of socio-cultural adaptation and involvement:** economic and geographic factors are not the only obstacles to providing access to healthcare and prevention. What use are good facilities if people are reluctant to meet workers or do not understand what they are prescribed? The socio-cultural adaptation of procedures, language, standards, values and care providers' relational skills are all also determining factors in access to healthcare. The implementation of health education activities adapted to the preoccupations, representations and practices of populations is essential to improving knowledge of risks and the benefits of child spacing, etc.

3 / **The principle of determining priorities and political cohesion:** collecting socio-cultural, demographic and epidemiological data must make it possible to determine priorities specific to each of the populations in question. Priorities that may concern people from a particular age group, gender or specific groups (refugees, asylum seekers, etc.). Priorities that may focus on specific prevention objectives, on support strategies for access to healthcare structures, on treatment of certain pathologies or on situations of dependence, etc. All these priorities need to be determined in consultation with the different populations, workers and partners, especially institutional, if a coherent healthcare policy is to be deployed.

The challenge of apprehension and comprehension of needs that are not always expressed

Needs are often perceived differently by aid and development actors and populations. During discussions, populations may express needs that might not seem important to the aid and development workers just as they may not perceive or view as serious a problem or illness. Very often, everyday illnesses such as infant diarrhoea, a high temperature or malnutrition are seen as "normal" or are put down to the supernatural. Added to this, people often express needs on the basis of what they think that the different organisations can provide them with: a medical organisation will hear about needs for medical care, an organisation such as Action Against Hunger will hear about nutritional needs and an agricultural organisation will only hear about issues relating to water or seeds, for example. It is therefore not an easy exercise to analyse a situation and identify needs (and/or concerns), health issues and resources; it supposes debate, conflict and negotiation.

Humanitarian actors have very specific roles to play in these approaches: their position is a tricky and complex one, often divided between the desire to adhere to the rationale and outlines of the projects, or to stand by the people to be supported who are not always close to the strategies and key aims of projects. We know that large institutional donors are sometimes at the root of fashionable trends in terms of the areas to be addressed, which may not correspond to the needs of communities – even if the donors would like to see these communities participate. The procedures (scheduling, budget management, regions for intervention, etc.) are not always compatible with the involvement of a community from the outset. Short-term projects, for example, present a major obstacle as they put pressure on the time required for their ownership and acceptance along with their continuity and sustainability. We will look at this point in more detail later on.

The growing discrepancy between the operation of healthcare systems, aid projects and their priorities on the one hand and the major concerns of the most socially disadvantaged populations on the other, call for an appraisal and a critical review of our practices. Working with communities requires real effort to forge good relations between all parties and to devise projects that are pertinent to all.

Ethnic challenges and the issue of acceptance

For the aid and development worker, working with communities means respecting people's dignity, recognising their right to have their say, their skills and potential, treating them less as "victims" or "beneficiaries" and more like true "stakeholders". This change in attitude is essential to increase projects' degree of acceptance.

Let us add to these requirements the capacity of aid workers to take other people's cultures into consideration and to forge relations based on trust. This is a real issue when the turnover of expatriate staff restricts continuity in relationships. But this continuity is fundamental for project anchorage, acceptance and sustainability. Trust is also essential in order to guarantee on-going feedback on projects in order to be able to adjust them so that they stay relevant to the changing needs of the populations, appropriate to these needs and accepted.

23. By **Vincent Pearce,** former security advisor to MdM.

THE ACCEPTANCE APPROACH: A PERSPECTIVE AND A SECURITY STRATEGY[23]

The perception of humanitarian organisations and their staff by the communities with whom they are operating is a determining factor for security.

Humanitarian actors sometimes assume that beneficiary communities know what a humanitarian organisation is, what it does and what its mandate is. And they think that once the organisation has been presented and introduced into communities, access to the populations, participation, approval, goodwill and protection are won, mainly due to the nature and the integrity of their action. However obvious it appears, the concept of humanitarian aid is not universal and is far from being familiar to everyone. What is more, the news regularly reports that aid or aid representatives are not welcome in some regions of the world and, in some cases, that they are even targets of violence. The reasons for these attacks are often independent of the organisations. Usually, it is because they are associated with government policies, armed groups and specific groups of populations, etc. So it is vital for an acceptable level of security that organisations be well thought of by the populations.

For many organisations, what is commonly called "acceptance" refers to what is now considered the best strategic approach in security terms. The purpose of an acceptance approach is to "reduce or eliminate threats by reinforcing acceptance (political and social consent) of the presence of an organisation and its work in a particular

situation".[24] This approach differs from protection and dissuasion strategies (also used, but to a lesser extent) as it requires a close relationship with the communities and on-going dialogue. It is now accepted[25] that an organisation that has elected to develop an acceptance strategy and therefore increase its capacity to communicate and negotiate with communities as well as with all other stakeholders in the field has better access to the populations and a higher level of security. However, it should be noted that no strategy operates alone. So a successful, overall security policy depends on an optimum and appropriate combination of acceptance, protection and dissuasion strategies.

The challenge of reconciling different types of knowledge: external knowledge as a support to internal knowledge

During the discussions at the Dhulikel workshop, we observed constant tension between so-called lay or traditional knowledge (traditional healers, herbalists, traditional birth attendants, etc.) and so-called scientific knowledge or "specialist" knowledge coming from elsewhere. Interaction between the two types of knowledge (internal and external) becomes possible when the population sees that the former is insufficient. This concerns not only medical knowledge but other types of technical knowledge too, as evidenced by the Nepali participant's account of the reservoir.[26]

Working with communities must also be seen as a way for aid actors to reinforce local knowledge and the capacities of traditional systems. Reinforcing and supporting lay knowledge make it possible to improve preparations for future crises. Thus, working with communities also means supporting local strategies and reinforcing the social fabric when it exists. When addressing an issue, it would be counter-productive to go against local strategies and capacities.

The challenge of advocacy

Participation by populations can enable the setting up of a process of advocacy for victims of inequality, particularly in the area of health. As these people are far removed from a medical culture, unable to take part in decision-making and/or have limited access to healthcare systems, projects should aim to:

→ Reduce their socio-cultural marginalisation in relation to health standards and practices by aid and development actors (once again we encounter the socio-cultural acceptability of actions issue);
→ Accord them a less submissive role by giving them back ownership of health and highlighting their ability to define the priorities and the type of aid provided to them in accordance with their own objectives (empowerment);
→ Opening up the healthcare system and the projects to their specific needs (accessibility).

Advocacy is therefore key to actions that respect the rights of populations. This necessitates discussion and working on community organisation at the political level; these can be set up by aid workers and/or on the initiative of local leaders and group representatives to defend rights and foster shared interests.

2 / THE CHALLENGES FOR POPULATIONS

Health: a question of rights and education

According to Alain Touraine,[27] an individual's dignity can be sustained by his or her capacity for protest and outrage. "It's about creating opportunities for freedom (...), not reconstructing an ideal society." The notion of participation makes the question of health a political and civil rights issue that people can freely debate from a perspective of equitable cooperation.

From this perspective, health is a right, the right to decent living conditions and access to preventive medicine and healthcare. Exercising this right presupposes public policies but also the personal capacity of individuals to enjoy the benefits. So community actions need to be initiated, starting with a core group from the population that organises itself to change a situation it views as intolerable. The fight against HIV/AIDS, for example – a movement inspired by an activist minority – shook up relations between the various partners in the healthcare system.

Healthcare: a resource for development

Health affects people's relationships with themselves, their environment, their history, their capabilities and their plans. Maintaining, increasing and restoring healthcare resources are all necessary to facilitating social integration. In their review of the literature on well-being, society, and institutional development, Bach, Muszynski and Rioux (1993: 98) suggest that well-being is just as important as health. People can achieve a high degree of well-being while living with a chronic illness or a disability. So health can also be seen as a "resource", not as an end in itself.[28]

Community participation: a challenge over power and a means of combating inequality. The notion of "empowerment"[29]

Promoted by the Ottawa Charter, the notion of empowerment has taken off in health and health education promotion spheres over the past few years. Difficult to translate into French, the concept is derived directly from the Ottawa definition of the approach to promoting health: "process that confers on populations the means of exerting greater control over their own health". Marie-Ange Freynet conveys

24. Humanitarian Practice Network, "Gestion opérationnelle de la sécurité dans des contextes violents" [Operational Management of Safety in Violent Situations].
25. Recent studies on operational strategies in run-down areas, besides a reference to acceptance as being the main security strategy, are beginning to define acceptance activities as well as statistics and indicators that have badly lacking up until now.
26. "For two years I have been working on a land reform programme where we try to solve the problem of the lack of land. There is a large water reservoir but not enough rain. We had landslides this year that damaged the reservoir. A water problem at a time with little rainfall. As a facilitator, I first proposed to clean the reservoir and someone from the Red Cross was called. The women and young women from the committee told us that it wasn't up to people from abroad to tell us what we needed to do. So I proposed to do what we could for the reservoir before getting somebody to come. That said, he came anyway but we told him that we knew the problems better than him and they ended up delegating the tasks to us."
27. **Alain Touraine,** *Pourrons-nous vivre ensemble ?* [Can We Live Together?] Fayard, 1997.
28. See the Ottawa Charter, OMS, 1986
29. **P. Augoyard, L. Renaud,** "Le concept d' "empowerment" et son application dans quelques programmes de promotion de la santé" [The Concept of "Empowerment" and its Application in some Health Promotion Programmes], *Promotion & Éducation,* vol. 5, 1998, pp. 28-35 ; **Y.D. Le Bossé, M. Lavallée,** "Empowerment et psychologie communautaire : aperçu historique et perspectives d'avenir" [Community Empowerment and Psychology: Historic Overview and Future Perspectives], *Les cahiers internationaux de psychologie sociale,* n°18, 1993 ; J. Lord, P. Hutchinson, "The Process of Empowerment: Implication for Theory and Practice", *Canadian Journal of Community Mental Health,* 1993, pp. 5-22.

the concept of empowerment as "active taking back of power by the person themself".[30]
Here, it means populations increasing their capacity to take action on their own health as a collective approach. This notion applies in particular to marginalised populations far removed from the benefits of healthcare systems and lacking power in this regard as well as in all others (economic, social, political, etc.). Empowerment would mean their capacity to further their cause. It is not just about increasing self-esteem but also moving towards greater responsibility and social justice.

This notion is based on four premises:[31]

→ Individuals understand their own needs better than anyone else;
→ Everyone has assets to build on;
→ Empowerment is for life;
→ Personal experience and knowledge are effective and useful in exercising one's power and improving one's living conditions.

The value of this approach is, of course, to focus on people and the group, and to develop their acquired or potential capacity to confront situations. Its limitation is that it is sometimes based on the illusion that participation and community action are straightforward and that everything can be planned for, negotiated and developed at the individual level. It is illusory to systematically think that vulnerable people are in a situation in which they can make the most of their resources to conceive or even take part in projects, sometimes drafted well upstream.

30. M. F. Freynet, *Les médiations du travail social* [Mediation in Social Work], Chronique sociale, 1995, pp. 281-289.
31. P. Augoyard, L. Renaud, *op. cit.*

2B

THE COMPLEX NATURE OF WORKING WITH COMMUNITIES

Working with communities is not straightforward and is a lot more complex than it appears. The participation of a person in collective action does not happen naturally but rather by construction, through awareness of belonging to a group. This raising of awareness may be through the experience of "working together", i.e., through the experience of solidarity. The community link cannot be dictated, it takes shape gradually.

But what do we mean when we speak of "community"? What does "community" mean to aid and development actors? And to the populations? What does "participate" mean? And, who can determine what the "communities" need? The research carried out before the Dhulikel workshop and the workshop itself endeavoured to provide some answers to these questions.

1 / WHAT IS THE NATURE OF THE COMMUNITY? SOME AREAS FOR CONSIDERATION

The semantic exercise put to the Dhulikel workshop participants (how do you translate community and what components make up the word in your language?) is instructive. For example, it reveals a fairly homogeneous

concept of community. The idea of "collection" in Bahasa Indonesia or the Papua New Guinea periphrasis **("everyone, clans, tribes, all the people living in the same area") are clearly very different meanings from the Vietnamese Cong Dong ("same situation") or the Fokolona** Malagasy ("people from the same ethnic group").

THE WORD "COMMUNITY" IN THE LANGUAGES OF THE DHULIKEL PARTICIPANTS

- In Nepali and Hindi: ***samudai,*** **derived from *samuha* = group.**
- In the language of Myanmar: ***ludu.*** ***lu*** **= people +** ***du*** **= group with an association to the word 'village'.**
- In Bahasa Indonesia: ***masaharakan*** **= collection + population.**
- In the Lami language (Papua): **there an whole phrase rather than a word for "community",** ***akemi inebunu lombok abok arek: akemi*** **= everyone,** ***inebunu*** **= clans, tribes,** ***lombok abok arek*** **= all of the people in the same area.**
- In Urdu (Pakistan): ***mohala*** **= a group of people living in the same place. Initially, the word was used simply to describe a neighbourhood, but it has evolved.**
- In Vietnamese: ***công dông*** **= addition + same situation.**
- In Farsi, **the Persian language spoken in Afghanistan:** ***jomma, jom*** **= group or team.**
- In Malagasy: ***fokonola*** **= people from the same ethnic group.**
- In Tamashaq, **the language of the Tuareg, spoken in Niger:** ***temoust*** **= identity.**
- In Chinese: ***qun ti*** **= group + body.**

So what we understand by "community" can vary widely, from a small group to close relations and exchanges, to a collective where only interdependent relationships exist between individuals who may never actually meet. This covers very different realities. It is difficult to know what actual reality we are talking about when we use the term "community".

The notion of "community" is a concept in the sense that it cannot be "touched" or even seen as a whole. Like "mountains", "rain" or "forests", communities can take different forms and have different sizes or locations. No two communities are the same. Several sessions at the Dhulikel workshop with participants from all over the world showed a great variety of definitions of the concept of community, probably revealing a wide range of expectations with respect to communities.

It becomes clear immediately that a community's contours are neither fixed nor even always visible: is it a space? A culture? A function? A reality or a dream? **There are a number of points to be explored.**

1st point : the community, a geographical location?

A community can be defined in terms of geographical location. In Nepal, Myanmar, India and Pakistan, a community is seen as a group of people living in the same location. Other countries add to this the notion of sharing the same resources and similar social and economic conditions (Vietnam).

Next there is often the question of the level of the community, with concentric circles from the most local to the most global. There is clearly not only one community level and choosing the right level is strategically important. In Madagascar, an MdM project was working initially at the village level (the *fokontany*, with around 1,500 people) to make contact with the community.

But an anthropological study[32] showed that it was not pertinent to engage the community at this level and that the smaller scale of "sectors", corresponding to districts originally occupied by extended families, was more appropriate.

So is a community limited to a location and the people there? We imagine, as often happens with projects, that a community is a village, a few kilometres away from other villages, in a rural area, with its boundaries at first sight appearing to be clearly delimited. But a community may have members who have moved away. There may be extended communities in larger areas such as districts or regions, etc. Marriage may link villages either side of national borders. A community may have inhabitants who marry people from very close by or from far away and who move away or bring their spouse to live with them. Inhabitants may have brothers, sisters, cousins or parents living elsewhere. Some communities move around altogether as in the case of nomadic communities. And, it is even more difficult to define communities in an urban context: a community may be a small cluster of several communal living quarters, a neighbourhood or district community or some other kind of local urban subdivision.

A community boundary is therefore not necessarily clear-cut: it may not even have its own location (it may be over several areas, even a virtual non-area); it may not only be made up of inhabitants living within a specific space (extended community, displaced members); it may be physically mobile (nomads).

2nd point : communities of shared cultures, values and common interests?

Since the spatial element does not define the community, participants gave definitions based on language and culture. In the case of the Tuaregs, "space is there to be shared, a house is a prison" and the community is defined only by the same language and way of life. This is a **value-based community.**[33]

And there are communities that are created intentionally: these are called **organised communities or value-based communities.** Urbanisation, for example, gave rise to organised communities that do not necessarily have a defined area or that did not come about as a result of a natural and unplanned process, and that can be found in cities. Indeed, cities are conducive to the grouping of people sharing the same interests and values. And now, with the advent of the Internet, we are seeing the emergence of new organised communities.

A community is not only a social but also a cultural entity inasmuch as it is made up of things that are learned, shared beliefs and symbols. Individuals' actions are based on shared expectations, values and beliefs. These values are learned from birth and this learning process continues until death.

We can also put forward functional definitions, on the basis of what the community permits:

This may be a place of mutual support, possibly with diverse cultures: some communities are made up of people who do

32. M. Bouchon, "Analyse qualitative de l'organisation communautaire et de la santé, Madagascar, district du Maroantsetra" [Qualitative Analysis of Community Organisation and Health, Madagascar, Maroantsetra District], January 2010.
33. This definition, however, does not match that of the Pakistani participants who feel that a community can be made up of people who do not hold the same values or that of the Indian, Malagasy or Indonesian participants who consider that a community can include people from different ethnic backgrounds or clans and even migrants.

not necessarily have the same origins or even the same nationality (a community made up of immigrants from different places). A community may be a space of shared resources, a place where no one is excluded and where minorities have their place (Myanmar). Mutual support is also based on complementarity as expressed by the Indonesian participants at the Dhulikel workshop via the metaphor of organs in the body: all different, all necessary for the correct functioning of the whole.

It may be a place where work is shared, where all the men, women and children contribute to productive activities and the protection and management of natural resources. In Madagascar, the image of bees and the beehive conveys this concept. In Myanmar, it can be a place for recreation and celebration, a place where festivities are organised. For some in the country, it may mark the boundary of leadership (a community around a chief, elders, and so on), while for others it is the contrary: "if there is a leader, there is no longer a community as then no one dares to speak out".

In any event, the community is rarely a culturally homogeneous entity; yes, it has cultural dimensions, but it also comprises different political, economic and social aspects.

3rd point : do we belong to just one community?

The use of the expression "the community" is clearly not that straightforward, since it conveys the idea that each individual belongs to only one single community. A person may belong to one village community bringing together everyone living in the same vicinity but also to a religious community and an ethnic community. A profession, politics, sport or hunting and many other activities that are capable of creating poles of interest may also be viewed as central to fully-fledged communities, each generating a particular identity among their members.

So the term "community" must not be used alone but qualified as in, for example, village community, Catholic community, etc. Alliances can be built up around all of these communities and initiatives can be taken; the setting up of tontines (savings and credit schemes) is one such example.

4th point : is a community simply a sum of individuals or a multitude of interactions between individuals?

Common to all of the above definitions is the introduction of the notion of a social link, i.e., customs, practices guided by norms with their system of integration and rationale of socialisation. The community is a sociological concept (in the sense of "social") inasmuch as it is a set of interactions and human behaviours that hold meaning and give rise to expectations among its members.
A community is not restricted to a group of dwellings or individuals. It entails social and cultural organisation.

5th point : long-standing communities, ad hoc communities, idealised communities?

Many people dispute the very idea of community or do not feel they belong to a community.

> "How could we be considered to be a community? We have no roofs".
> **One Indian participant commented in Dhulikel.**

This complicates the concept of community practices. It is stating the obvious, but for there to be a "community spirit", to start off, all the members of a community need to be aware of the fact that they belong to it and identify with it.

A community is not necessarily permanent, it can also be temporary, rallied or to be rallied: there is the community we would like, the kind of community we dream about perhaps, based on the idea that there is safety in numbers and that it can be put together to confront a problem, abuse or an injustice, etc. However, caution must be exercised when using the term "community" and even "group" as people with common characteristics (drug users in Afghanistan, people living with HIV/Aids in Vietnam, female Chinese sex-workers in Paris, and so on) do not necessarily want to form a group, even if it is to defend their interests. Can a group be created on the basis of what people are going through? It may be a sociological reality but from the psychological and personal point of view, it is often contrived.

> "Drug users are seen as criminals and naturally there is a reluctance for people to say they are members of this community. When we go to do outreach work in the street, we don't talk about a community". **A peer educator in Afghanistan**

In reality, the Chinese women from the Lotus Bus[34] are very isolated and even though they speak the same language, share the same difficulties (police harassment, violent clients, etc.), immigration status and their work in the sex industry, the feeling of belonging to the same "community", even the same "group" does not exist. Harassment does not contribute to creating a sense of community either in Kabul or in Paris.

Stigmatisation and repression are sometimes so bad that a bond cannot be forged between people. So how can a community approach work and have positive results?

In other words, how can stigmatisation and criminalisation be prevailed over to enable the forming of a group? In the case of people living with HIV/AIDS in Vietnam and drug users in Afghanistan who do not see themselves as part of a community, it is thanks to the actions of these people through peer educators that it has been possible to begin to combat discrimination and improve access to care. Underpinning this is the belief that good leadership strengthens a community and puts it in a better position to fight for its rights and access to healthcare.

Working with a peer educator also makes it possible to create opportunities and the time to talk. The peer educator can talk to these people about what they are going through. This opens up time and the opportunity for discussion. In the case of the Chinese women in Paris, it was observed that they had no place or time to talk or to get to know each other. These forums are places where they can relax and realise they are not alone in their situation. MdM teams have seen that they are very scared, ashamed to speak to each other and that they need to be helped with talking things through as, besides providing support, they can also pass on important information: several women had been raped by the same client and sharing this with the other women kept them out of danger as they refused to provide their services to him.

So community spirit may have more to do with myth than reality. The example of community health centres in Mali speaks volumes:

34. The Lotus Bus programme promotes health among female Chinese sex workers in Paris.

LIMITATIONS OF THE CONCEPT OF COMMUNITY: THE EXAMPLE OF COMMUNITY HEALTH CENTRES IN MALI[35]

Lassana Siby, who was behind the foundation of the first community health centre in Mali in 1988, suggested the use of the word "community" for this new kind of facility because "the donors like the word community," he said to explain his choice. In fact, the donors so liked the word that they contributed to its adoption by the Health, Population and Rural Water-Engineering project run by the Ministry of Health with financial backing from the World Bank. It then went on to be included in the "Sector Policy Declaration" text that was to accompany all projects supported by the bank. The ASACO (Community Health Associations) and CSCOM (Community Health Centres) came into being.

Among the different arguments that explain the infatuation with the word "community", two types of represen-tations/ perceptions for this word are worthy of mention:

- **→ Community means equality and sharing. It is the group versus the individual. The organisation into "communes" of local collectives, the "Paris Commune" of 1871 and the "Communist" system are all historical facts that have contributed to giving the word an ideological connotation. Remember too the events of May 1968 and their impact on the perception o f this concept: the departure from the "bourgeois" world by many 1968 protesters to "communities" transformed into reality a current of thought that turned the word into the symbol for a new way of life.**
- **→ The community is Africa, with its stereotypical images dating from colonial times. It is the village pitted against the city, collective property versus that of a minority, discussion versus solitude, democracy versus the power of an oligarchy, solidarity versus indifference...**

In the West, the combination of these two visions has led to the adopting of a position that makes the community the cornerstone of a specific type of development.
The "community" nature of CSCOMs was designed to be based on four major principles: they are set up on the initiative of "a" community: it is the "community" that takes all crucial decisions; they are managed by "this" community through the association of users representing it; they are in direct contact with the "community", they are responsible for the health matters that the "community" considers a priority.
But analysis shows that numerous community health centres are the subject of major deviations that challenge the reality of their community identity. Studies in Bamako have shown appropriation of these centres by power groups that are not in keeping with the ideological notion of "community". General assemblies have become the exception, the all too rare committee meetings deal only with day-to-day issues and the chairperson often takes important decisions alone. Few budgets are approved and accounts are not transparent. As the choice of delegates is at the discretion of the villages, this means that "influential people" co-opt their representatives thus reinforcing the reality of the powers in place, be they traditional, religious or financial. Although committee meetings are held from time to time, they consist mainly of approving proposals made by the health district's head doctor. The committees set up on the initiative of these doctors feel that they are directly under their authority. Accustomed to being subjected to the demands of a central power, they are all the more inclined to accept this subjection as it gives them the legitimacy to exercise power over the other members of the association. Thus, the concept of community is limited to a simple declaration that gives "community health centres" a "politically correct" image at a time when it is fashionable to speak about "community", decentralisation and democracy.
The reasons for this deviation may lie in a misunderstanding of the concept of community due to the complexity of the concept itself.

So when conceiving projects, we may shy away from the image of an idealised community conveying an idea of harmony and consensus. One we often come across sees the "village" as the standard model of what might be considered "the community". An African village seen as a homogeneous entity evolving under the authority of a traditional chief surrounded by his counsellors under the palaver tree, the symbol of African democracy, often conforms to this image of the community.

Moreover, it is common, in the vocabulary of aid actors, to hear, "You have to consult with the community..." or, "The community has decided to..." In certain types of approach, the word of the village chief commits the whole "community", and none of its members questions its legitimacy. However, the decision that has been taken will affect the village as a political institution but will in no way be binding on each individual villager. An affirmative response by a village to participation in a project with community action is not necessarily a reflection of adhesion to this principle by all of its members. Take the example of the prevailing social organisation in a Mali village, whether Bambara, Peul or Songhai. Its unity rests on the principle of a fundamental inequality between its members and the importance of force (fanga to the Bambara) in the exercise of power. The rights of each individual within the village are above all determined by their family, age and gender. Just as there is a hierarchy of rights between men and women and between age-groups, there are considerable differences between those who are "nobles" (horon) and those who are not.[36] There are also differences in rights between noble families who have access to the chiefdom and those who do not, between "local" families from the village and "foreign" families, between families that do not belong to the dominant ethnic group and the others (Peuls in a Bambara village, for example).

We are also seeing a significant evolution in social relations related to money: whatever their family origins, age or gender, a person of wealth sees their social status rise in direct proportion to the size of their fortune and their sphere of influence.

35. **H. Balique,** 2001, "Le concept de communauté et ses limites : à propos des centres de santé communautaires du Mali" [The Concept of Community and its Limits: Concerning Community Health Centres in Mali], **B. Hours** (dir.), *Systèmes et politiques de santé : de la santé publique à l'anthropologie,* éd. [Health Systems and Policies: From Public Healthcare to Anthropology] Karthala, collection Médecines du Monde, Paris, 2001.

36. In Bamana societies, members of the family said to be "caste" (nyamakalaw) are not nobles. They are mainly blacksmiths, griots (storytellers) and shoemakers, as well as the descendants of former families of slaves (wolosow), **H. Balique,** *op. cit.*

6th point : does a community define itself by its needs and how to assess these needs?

A community approach can be based on the belief that community members share similar needs and similar expectations. Is this necessarily the case? If we accept that, for example, a village does indeed constitute a community, the extent of the inequality that frequently exists between its members must be established. A minority whose only legitimacy is birth, money or political relations sometimes takes the decisions. We are often all too quick to assume that a community is run harmoniously, as is the notion of "common needs".

Aid actors' use of the notion of "need" seems to be derived from practical evidence and the guarantee that the action will serve populations. But the notion of need may be derived from social representation that does not necessarily correspond to the way the group functions, which is rarely guided by a single rationality, without conflict. It is difficult to understand populations' "needs" when they are treated as a homogeneous mass with no variations in standards of living or authority. Communities are often rife with multiple factions, fights and conflicts arising from differences between individuals with social divides that sometimes last several generations. At their origin, there are clans, social classes, age-groups, gender, ethnic groups, language, religion, money, etc. In short, all of the components that make up the social organisation.

The understanding of social positions within a community is far from being simple and the "community" can also be seen as limiting to the rights of the individual. In a group, there are people who are "more equal than others," and unequal power relations and domination are legion. So, it is important when promoting community projects not to have too idealised a view of the community.

Beyond power relations, communities can restrict their members' freedom to act and it can be difficult for individuals to decide on their religious beliefs or political choices. In small communities where everyone knows each other, there are unofficial means of social regulation such as gossip (rumour, etc.) rather than laws or rules. The community is also therefore a place where an identity is imposed and where an individual can be prevented from becoming an autonomous person, the creator of his or her own history.

7th point : how can we work with marginalised communities?

In relation to what has just been said, working with marginalised communities can carry the risk of reinforcing the stigmatisation of these people by identifying or categorising them. Examples are groups of people living with HIV/AIDS and women victims of domestic violence finding refuge in dedicated centres. Their position needs to be understood not only in terms of closed categories (ethnic group, religion, class, gender) but also within a dynamic social context in order to reduce stigmatisation (a person is much more than a patient living with HIV/AIDS).

DEBATE ON THE ISSUE OF "MINORITIES"[37]

The term "minorities" is often used to refer to the most vulnerable members of a community and can also extend to include ethnic groups, people of different faiths or victims of a particular problem, etc. A truly vast term, a catch-all, it is not necessarily in keeping with the name, given that "women", for example, are considered minorities in many societies. It is therefore essential to understand how the community itself categorises these groups of populations (the old, single women, the disabled, etc.). Serge Moscovici marks off two main categories:

- **"Nonconformist" minorities where we find "dissident" minorities that endeavour to create an identity based on social values other than those of the prevailing model and "delinquent" minorities that operate through rejection and offence, and develop asocial behaviour.**
- **"Dependent" minorities that either adapt to comply with values and standards ("adapted minorities") or who are unable to establish a social identity ("unadapted minorities").**

37. S. Moscovici, *Psychologie des minorités actives* [Psychology of Active Minorities], PUF, 1979.

8th point : introducing projects into communities: a process of social change

The social and cultural organisation of a community is, to varying degrees, modified when it is used and organised around community projects as these introduce new behaviours/values/objects. Intermediaries, workers and peers become agents of social change.

Social change brought about within a community through participation in a community project resembles acculturation.[38] So we have a duty to understand the nature of the social change we trigger in a community.

During the process of social change, it is important to differentiate between what happens to the whole community from what happens to the individual. What affects an individual in a community does not necessarily affect the development of the community.[39]

Projects bring different types of ideas, behaviours, techniques (Information, Education and Communication messages, pharmaceuticals, new care providers, latrines, etc.). Not always completely unknown to the populations, they may not have been available to them. This calls for being prepared to understand the effects that the introduction of a change in the community can have on it as change is not easy to anticipate and not always made in the right direction.

First, projects have repercussions on the economic organisation of a community: all communities have different ways of distributing wealth. It is important to know how it is distributed, under what conditions and between whom, what cannot be bought or be given, etc. For example, in the case of the drilling of a well, the traditional system of distributing water must be known, as it may have been done using very different economic systems (flat rate? filling?)

Next, communities all have their own political system and there is an imbalance in the

38. Culture consists of all these things, actions and beliefs that people learn. This includes acquired rather than innate behaviour: it is the difference between nature and culture. Culture is preserved and transmitted by symbols, some is learned during childhood (such as language) and some acquired in adulthood. The process of the child's initial learning of culture is called socialisation or enculturation. Re-learning this when a person moves to a new society or his/her community changes is called acculturation.

39. A community is organised and operates even though its members come and go, are born and die. For example, people living in a community convey a belief, but this belief will live on even when these people die. It is the same with a custom or a convention (shaking hands), an institution such as marriage; it is greater than the individuals who pass it on.

top and bottom levels of power between individuals/groups. This demands knowing how power and influence are distributed and what changes are under way. Some projects have an impact on this organisation of power by encouraging the setting up of village committees, for example. Setting up a committee introduces a new political component in the community. Each time a new entity is created with its accompanying duties and responsibilities, the community becomes more complex. Encouraging the training of community workers, for example, makes the community more complex as it introduces a new role and new relationships.

Lastly, the community must be encouraged to choose the model that is consistent with its prevailing values and attitudes and not to underestimate the changes that external intervention causes on the community value system. Values are not innate but acquired by the child during the culture learning phases known as the **socialisation phase.** This implies that they can be re-learned, that their own judgements can be changed. Values change as community models evolve, but this change cannot be precipitated or guided by an external influence or conscious manipulation.

A project can be perceived as an attack on existing values within communities. In some cases, such as those addressing gender-based violence in countries where domestic violence is not punishable by law, it may be counter-productive to announce from the outset the intention to change those values, even if this is clearly the project's intent. Change may occur through more indirect means (for example, isolation and a lack of education being some of the many factors behind domestic, gender-related violence, raising men's awareness of the need for women to have access to financial resources and education may be more appropriate than direct action).

Examining and understanding a community's predominant values, being attentive to its members and their beliefs, proposing rather than imposing, these are the conditions to allow coherent actions that are more or less compatible with the prevailing beliefs and values that are acceptable to the community.

2 / CONCEPTS OF "INVOLVEMENT" AND "PARTICIPATION": UNDERSTANDING THEM AND THE ISSUES

One of the ideas retained in developing the notion of community health is that of actively bringing individuals, populations and groups of citizens together to participate in all the different aspects that involve them, including decision-making. This then leads us to ask: what does "actively bringing together" mean? Does this expression not imply that the participatory approach is in fact, and at least at the beginning, promoted from the outside by donors a nd NGO head offices? Does "actively bringing together" not signify that populations enter into a participatory strategy in which they did not have the initiative and that is not always based on the same meaning of participation as those who want to bring them together?

Community health is part of a threefold dynamic process: dialogue, intersectoriality and participation. It may take very varied and sometimes contradictory forms and presupposes adaptability, methodological tools and consideration of power issues. This notion also presupposes that empowerment is a right.

Participation is first and foremost the result of an encounter between different cultures, beliefs and knowledge. It implies the building of an interrelationship between groups, communities and outside aid and development actors and requires trust and mutual respect in order to understand the different parties' expectations and objectives. Its success depends ultimately on each person's ability to understand and respect each other. It is the individuals, the population and the aid workers, who are the actors in this process. So their experience, personal stories and aspirations will necessarily impact the project.
Participation can be understood as the participation by populations to a greater or lesser extent in one or several aspects of a project: diagnosis, programming, implementation, follow-up and evaluation. It implies that the project stakeholders are ready to listen to what the people have to say and to rethink and perhaps change their objectives.

Reminder: The participation of populations in the resolution of health issues is a cornerstone of community approaches. It is one of the main elements in the Ottawa Charter and presupposes the possibility and will of individuals to become involved in debate and joint actions with people affected by the same issues. "Participation" and "involvement" in this context are often used indifferently. As the community approach is not static but in flux, it is found at different levels of actions that can be described as "involving" populations or making them "participate" in actions. It is perhaps not very important to make rigid distinctions but to try to improve involvement and participation in the most appropriate way possible.

Participation and the degree of involvement by the population are clearly different, depending on the situation and the setting: urban or rural, emergency, conflict or in peaceful times, chronic emergencies, etc. Generally speaking, there is a real lack of clarity on what people understand by participation. It is often a cultural problem (including between different social or professional classes) that goes beyond that of vocabulary.

For some, participation is crucial, for others it is "a bonus" while, for others, it is an added value/advantage or a waste of time. Sometimes there is the feeling that "participation" is often just a way to get others to say what one wants to impose on them. It is, in the words of Michel Sauquet, "the barrel organ technique: we get people to talk, we pass swiftly over what doesn't interest us and only retain the elements that will corroborate our message, just as the organ only lets the needles under the holes in the cardboard through".[40] These different perceptions of participation are not necessarily either conscious or intentional. They may simply be adopted through routine, hence the need to give aid and development actors time and space to take a step back from their work by, for example, holding knowledge-exchange workshops with teams, partners and beneficiaries.

"I didn't think the project up, I didn't draft it, I changed it. In my sub-region we are often told, "write the project quickly" and we don't have time to work on it because of the donors' deadlines but afterwards, we stick with it, tweak it or change it." **One Nigerian partner affirmed at the Dhulikel workshop that acceptance of the word "participation" by NGOs is sometimes very utilitarian.**

40. M. Sauquet, *Le voisin sait bien des choses. Communication et participation en milieu rural : leçons du cas brésilien* [The Neighbour Knows All Sorts of Things. Communication and Participation in Rural Environments: Lessons from the Brazilian Case], Syros, 1990.

The fact that the donors' deadlines are tight does not help to involve communities in the project and fundraising is a major factor in determining the extent of participation. Often, communities simply do not have the choice of getting involved - or not - during the set-up phase of projects.

For some, the word "participation" is almost a kind of evidence, for others, particularly those from the southern countries, the concept is quite hazy and vague, only becoming clear when replaced with the term "involvement" and combined with the notions of belonging or trust. The question of populations' "willingness" to participate can also be posed.

"but when I get back from the field, I don't feel like doing accounts and if I'm ill, I want to be cured".[41]
A Malagasy villager.

Another factor influences the types of community involvement in projects: past experience or the memory a community has of previous projects. Populations used to projects with little participation may not feel concerned or may allow some of the stakeholders to try to divert a project in favour of more personal interests. Some projects may have left people disappointed; memories of such past experiences have to be addressed. They may have instilled passive expectations too and which are difficult to overcome; this is the case of projects focused on distribution: microcredit for women, agriculture-food and nutritional projects providing raw materials, school canteen projects and projects with high incentives.

On the difficulty of outgrowing habits, as witnessed by a member of a partner NGO in Nigeria

"This project is in remote areas with a high illiteracy rate. So it is difficult to convince people of the value of the project. It was a first, a project that wanted to try to change behaviour through discussion, participation and awareness-raising. For the people, a project means handing out millet and goats. This new approach was not easy as it is they who had to play a part and that's difficult in a developing country. There is such a sense of fatality, that there are better things to do than philosophise when one is thirsty or hungry. [...] People have difficulty understanding us and accepting above all that we have nothing specific to offer other than discussion and that was not easy at the beginning, but now people are starting to listen to the facilitators. It is true that initially the men said, "This is all very well, but we need food, we need healthcare". It is a new approach, but the people are misled by what they can actually see, equipment, the drilling of wells and distribution of livestock, like there were in the past in the area. We had problems with these people because they were misled by other projects."

Community participation is neither a given, nor spontaneous. It must be understood as a system of heterogeneous collective behaviours that refer to different perceptions, representations and practices. Studies carried out in the 1970s by the Centre d'étude des mouvements sociaux de l'École pratique des hautes études (Centre of Study for Social Movements of the Practical School of Further Studies), in particular by Albert Meister, **set out four major forms of participation:**

- → The **participation-contribution** of those who play a part in determining the directions to be taken by society, in decision-taking (leaders, chiefs, etc.);
- → The **participation-identification,** or dependent participation by those who are part of the objectives (associations, beneficiaries, etc.);
- → The **participation-survival:** participation by small minority groups founded on the basis of mutual aid within the framework of traditional solidarity, but which may reinforce isolation and the perception of the community as a "ghetto";
- → The **participation-protest:** arising from protest and creation of autonomy (women's rights, for example).

According to Dumas and Séguier,[42] **the principle of participation must be included in five dimensions of an individual's development:**

- → Individual awareness-: the person must feel personally concerned by a social or health problem;
- → Collective awareness-raising: this means groups, communities, members of collectives that will pool resources in order to generate solidarity;
- → Social awareness-raising: questioning circumstances, a situation;
- → Political awareness-raising: better perception of how society functions, seeking alternatives and possible solutions;
- → Emancipating awareness-raising, "We take action with others, we try to institute alternatives in our own lives; it is a matter of changing the conditions of one's everyday life, transforming relations with the environment and building a society".

Even though it is absolutely crucial, **working with the community right from the outset is for several reasons a challenge:**

- → Many people see participation as foreign to their culture. In highly hierarchical societies, few people are used to taking decisions or being involved in a system of collective decision-making. They may not feel it is "their role" or that it is their place to voice an opinion;
- → For a community to participate in a project, there needs to be a minimum social structure. In an emergency situation, this may be compromised or even cease to exist.
- → There may be a lack of specific technical know-how within communities;
- → The time required to explain the technical aspects of a problem to people who know nothing about the subject is often considerable;
- → An NGO with rather inflexible intervention or difficult to adapt project management procedures ("kits")(such as the keeping of registers or lists) for populations who are illiterate or simply unfamiliar with such practices, may find itself up against serious difficulties.

3 / CONDITIONS FOR IMPLEMENTING **EMPOWERMENT** APPROACHES

1st condition: taking into account differences in temporality, depending on the stakeholders

41. **M. Bouchon,** "Analyse qualitative de l'organisation communautaire et de la santé, Madagascar, district du Maroantsetra" [Qualitative Analysis of Community Organisation and Health, Madagascar, Maroantsetra District], January 2010.

42. **B. Dumas, M. Séguier,** *Construire des actions collectives. Développer les solidarités* [Constructing Collective Actions. Developing solidarity], Chronique Sociale, 1997.

> **"Time is against us. It just begins and it's over, it's as if we hadn't done anything." The facilitator of a reproductive health project in Niger.[43]**

The community often has more time than the aid and development stakeholders (NGOs, donors, etc.). While for many, working with communities is an important component of aid, for others, this work may be seen as slowing down and holding back the "effectiveness" of projects.

From the community's standpoint, the haste of outside aid workers is often seen as a problem. Aid and development actors and community members have different perceptions of what is urgent and what is not. For a Malagasy farmer, matters of urgency are managed from day to day and mean making sure that food is put on the table. Forecasting the arrival of a cyclone in three days time is intangible, theoretical and certainly not urgent or a priority compared to everyday problems. It is difficult to get them away from their fields even just for a few hours for an emergency that is three days away...

> **"You must let us know when you're coming as we have to stay here, we can't go to the fields and it interferes with our activities." One teacher from a village in Madagascar put it.[44]**

The rationale of the community approach implies very long consensus-building processes. The number of meetings that need to be held for communities to "understand and take ownership of" the project should not be underestimated, all the more so when addressing very different audiences. Partners in the southern countries frequently insist on the fact that if local stakeholders have not been able to take the time to take ownership of a project, there will be nothing left once it's over.

That said, the time issue is still almost insurmountable due to the tug of war between, on the one hand, the need to take the time to become familiar with the setting and associate communities with project planning and, on the other, constraints related to donors' demands (reports, "performance") and funding opportunities.

2nd condition: taking the time to build trust

Aid actors are not always able to take a step back to appraise their modus operandi and how they interact when they arrive in an area, particularly in an emergency situation. They are not always capable of seeing the frustration that may be created among populations that do not always know why projects are being organised. The constant flow of vehicles, questionnaires with mysterious objectives, comings and goings, can all be sources of anxiety for populations shaken by a catastrophe. A lot of time, a lot of patience and many explanations of the reasons behind an intervention, the methods, the way of functioning and mandate of the NGO are all essential to establish a climate of trust. An MdM project in Niger generated considerable mistrust, as the choice of villages for community action had not been explained.

43. **M. Bouchon,** Internal Evaluation Mission Report by S2AP, Advocacy Action Research Project, Niger, MdM, Feb. 2010.
44. **M. Bouchon,** "Analyse qualitative de l'organisation communautaire et de la santé, Madagascar, district du Maroantsetra" [Qualitative Analysis of Community Organisation and Health, Madagascar, Maroantsetra District], Jan. 2010.

> **"Even at NGO level, a certain village is going to be given more consideration" than other ones, because the person carrying out the survey knows someone so it is not always objective." The chief of a Nigerian village confided.[45]**

A participatory process requires time for talks, debate, negotiation and decision-making. Not taking time means there is a risk that not all of the words are heard, inappropriate people are endorsed and key steps omitted.

Furthermore, the time issue cannot be dissociated from the location issue:

- → More time needs to be set aside for people who move around (migrants, Roma, nomads, etc.) than for sedentary people to ensure regular contact and understand how they move around, etc.;
- → The need for proximity – being as close as possible to the people is often a real problem, in particular in some programmes in France where contact with people is sometimes short-term and can be broken off (evictions of Roma from camps, destruction of refugee squatter camps in Calais, short-term contact with Reception Care and Orientation Centre (CASO) users, etc.). In these cases, it is plain that involving populations in developing and following-up projects is more than a little difficult.

3rd condition: taking account of phenomena of breakdown in weakened populations

In some situations (conflicts, natural disasters, etc.) communities can find themselves totally broken down. Such situations make the participatory mechanism far more difficult to institute on account of the psychological and physical damage, or the loss of cohesion endured by people. Similarly, collective action can be more difficult to put in place in urban than in rural areas due to an impression of lack of cohesion and the fact that people are spread out.

It is particularly difficult to implement a participatory approach for groups of refugees and displaced people. These are often highly heterogeneous (different nationalities, ethnic groups, languages, religions, social statuses, etc.) with disparate needs: for example, there is a difference between the needs of recently arrived people and those who have been living in a camp for several years. The new arrivals may be far from their families and their home communities, making them even more vulnerable. Other forms of authority and social rules may appear within these groups. In addition, these people are not usually looking to stay in the camps, so they probably do not see the point in getting involved in projects. Implementing empowerment approaches therefore requires flexible projects and the identification of good intermediaries. Working with communities does not mean working with everyone – some may be too fragile – but it is important to ensure that even the most vulnerable can at least be represented, while trying subsequently to bring them into the project.

4th condition: taking power relationships into account

In his studies on development, and more particularly in Niger, anthropologist J.P. Olivier de Sardan recalls the importance of a methodological stance capable of identifying power relations ands the conflicts that occur in all social groups. He refuses to posit a "community consensus". There are non-

45. Interview during the evaluation of the Research Action Advocacy project in Niger.

consensual elements within societies. Each stakeholder, he believes, creates strategies and for individuals, everything has the potential for challenge and conflict; power relations are inevitable and even necessary. The participatory approach complicates matters: it implies that the external facilitator (with what legitimacy and on the basis of what criteria?) or the community gives power to certain people and impacts pre-existing power relations.

Certain people in a community can be identified as representatives, capable of speaking for the whole community. But these representatives may be from dominant classes or with dominant status, and their interests may be more specific or differ from the collective interest or that of the most vulnerable populations. The challenge is to identify such people and try to understand them to be able to take them into account in the project, in advance. Understanding conflicts of position, interest or stakes in health matters makes it possible to identify the different groups for the focus of the project and adapt communication supports and strategies accordingly. In this way, they will take into account the individual and relational challenges arising from a particular issue.

Giving power to the most vulnerable upsets power relations that are, by in large, not in their favour and the inevitable adverse effects need to be anticipated. In emergency situations, helping a population sometimes implies going through power structures that may have contributed to the marginalisation of certain groups.

5th condition: taking into account, not stifling local initiative and collective dynamics

Devising a project without taking account what already exists locally may run counter to the capacities and the objective of empowerment.

> "Our traditions are important. When somebody dies, there has to be a meeting, we must eat together and go to the cemetery for the burial."
> **Village chief, Madagascar**

There are traditional forms of solidarity in the villages of Madagascar. This is the case of the *fandriaka* ("mutual aid" in Malagasy), or, of *Tambirao* (from *tambi*= ask and *rao* = something that is mixed with rice, like stock). Understanding this message well, Swiss NGO Medair followed their example in its community actions to clean up the city of Maroantsetra in northeast Madagascar. Two zebus were killed and each district got organised to dig their canals.

> "There are three of us, one day we go and work in the first person's field, then the second day we go to the second person's field and on the third day, we go to the third person's field. And that way we take turns, it works even if there are ten people".
> **A villager in Madagascar.**

> "If you want something, you ask for it and the person who gives asks for work in return. When you wanted to dig a canal in a village or repair a road, that's what our grandparents did. A zebu was killed and plenty of rice was prepared, and on returning from the work, everyone ate together as a community. You worked first and after you went to eat".
> **An elderly man in Madagascar.**

Outside intervention can stifle traditional solidarity practices. Creating a community association to support a particular project can then weaken the traditional associations.

> "I have been appointed president of a sector association. I am now also president of the hulling machine. It's true that I am involved in a lot of things, that and the church. I no longer really manage to get things done in the neighbourhood aid association, which has slowed down since the arrival of the machine."
> **District chief of a village in Madagascar.**

Each community has an organisation, even though it can be destroyed or superficially thrown into disarray by a catastrophe. Efforts must be made to work with what already exists, to manage power relations, but without excluding marginalised and minority populations. Similarly, it is important to identify the different types of leaders in a community: administrative and traditional authorities, charismatic individuals, etc. The existing decision-making system must be helped to develop in order to foster collective decision-making and cohesion in the community.

It is particularly difficult to implement the empowerment approach in emergency situations. For many aid actors, this means being able to reassess and challenge their initial professional culture and question certain representations and approaches, especially those concerning the emergency response. As anthropologist Sandrine Revet observes,[46] not everyone affected by a disaster is destitute and waiting around for foreign aid. People can turn to their extended family or neighbours for assistance, for example. The hours and days before the arrival of emergency humanitarian relief are truly organised and not the total chaos we might sometimes imagine. The "emergency culture" of national and especially international emergency teams, with what it presupposes of generous precipitation, can push these early aid efforts out of the way. In the aftermath of a disaster in Venezuela studied by Sandrine Revet, the evacuation of children was prioritised, which led to trauma for families who ended up separated from their children, and it was very difficult to reunite families afterwards. During the days following a disaster, emergency relief workers organise emergency accommodation, which often takes in nuclear families (mother, father and children) but not the extended family (grandparents, uncles and aunts, etc.). As the situation continues, the long-term social aspects become more complicated, in particular childcare that is usually entrusted to an extended family member, as the social network becomes utterly disorganised.

4 / PARTNERSHIP AND NETWORK ISSUES

For many organisations, partnership is a means of involving local associations in response and aid activities, and thereby involving the population. But the settings in which projects take place are often politically difficult with a high risk of manipulation and misappropriation, and may compromise or discredit the perception of the populations who we are seeking to assist. So it is important from the outset to have a clear understanding of who is who in the local arena. In order to do so, a good diagnosis must be conducted beforehand.

From an organisational point of view, a partnership is a relationship that must be based on joint definition of objectives

46. Summary of the forum "Culture(s) et/ou culture d'urgence" [Culture(s) and/or Emergency Culture]; www.medecinsdumonde.org.

and the means of attaining them, shared responsibilities and mutual learning.

Partnership with existing associations and informal local groups is difficult, on account of their multiplicity and dispersed nature. In addition, there are few villages that have not lived through several successive and sometimes simultaneous projects with no coordination. So it is impossible not to take into account the local history of these past interventions that have a profound effect on populations' perception of outside aid and development actors and can have repercussions on the acceptance of current projects.

Partnerships are difficult but crucial: partners are often cultural interpreters who know the area and the organisation of the community well. Their local grounding confers them a role of "project brokers" and makes it possible to take over and keep activities in place.

Some of these partners often become central in giving credibility to an initiative or project. This is the case of local, public and religious authorities.
An alliance with religious authorities in particular is sometimes the best way to lift taboos and engage in debate on sensitive issues.

"The change today is that you can talk about family planning on the radio and in the mosques, whereas before no one dared mention it."
A community facilitator in Niger.

In Papua New Guinea, Pakistan and Niger, even though the clerics are reluctant to take a stance on certain issues (family planning, domestic violence, etc.), MdM teams defend their decision to work with them:

"Not much can be done without their approval and they carry more weight in some areas than in others".

So working with the imams' representative in Niger on a reproductive health project made it possible to legitimise action and also protect the project and facilitators from the risk of rejection:

"The village marabouts were the obstacle, we had to do a lot of work with them to first convince them to pass the message on. Many are not ready to preach sermons about these messages and we were turned away from the sites. If their imams had been convinced, all these problems would disappear and the team would not be turned away. They were extremely reticent about working on family planning."[47]

Efforts must of course be concentrated on cooperation with open-minded religious leaders who are willing to explain why such and such a practice is in keeping with the culture or religion in order to put a stop to taboos. This was the case in Niger, where cooperation with an imam made it possible to improve the results of a family planning project and promote the use of condoms. Islam, some clerics recalled, recommends child spacing; the prophet's companions practised it. But in Niger, where the religion is often not well-known by those who practice it, child spacing is condemned on moral grounds and by fundamentalist groups who also advocate the rejection of aid and development actors who they accuse of promoting behaviour that runs counter to Islam.

47. M. Bouchon, Internal Evaluation Mission Report by S2AP, Research Action Advocacy Project, Niger, MdM, Feb. 2010.

"There is a major taboo here. For the people, family planning is illegal, it's a crime. The imams and traditional chiefs are responsible, as they decide at community level. […] Thanks to their involvement, the facilitators have the courage to talk about sexual matters, but some people like the elderly cannot talk about sex. When there is an imam, you can talk about Islamic practices in relation to sexuality as the groundwork has been laid".
A partner from Niger.

It was noteworthy that in this area all the different actors were still talking about the imam's preaching tour even though it only took place once a year. This major inculcation, certainly the work of a very charismatic and highly committed man, shows how much the activity was appreciated.

Contact with public or traditional authorities is no less important, even though it is complex (questions of legitimacy, acceptance or otherwise conflict, misappropriation, loss of credibility, etc.). Awareness of local political and social dynamics is essential, in particular because cooperation with the authorities is often necessary to legitimise a project and work with a community, but also to limit diversion of the project for ends other than those intended.

The link with the different types of authority was largely tackled during the Dhulikel workshop and we were able to see the vast diversity of situations in terms of cooperation. In Pakistan, the connection between the public authorities and MdM is manifest as the organisation provides support for the *dar-ul-aman* – refuges for women managed by the government.
In Niger, it is one of "good will" inasmuch as the team works closely with state workers.
In Indonesia, the connection is tenuous:

"The government of Niger is aware of what's going on. Furthermore, many of our meetings are held in state dispensaries. And we work with state health workers".

"State workers do absolutely nothing and everything is designed to make up for the lack of action".
Indonesian delegates at the workshop.

And, in Afghanistan, relations are frankly hostile as the authorities, and particularly the police, are opposed to even the principle of harm reduction in drug use.

So relations with local authorities are not always without their problems. For example, in Pakistan, MdM tries to work with the Jirga in some cities. These are more or less official traditional assemblies for settling conflicts that people turn to before ending up going to court. But the judgements they deliver may not be in keeping with human rights. So, somebody in favour of human rights in these assemblies needs to be identified so that they can ensure that these are respected in any judgements.

Furthermore, relations with authority have an influence on participation in MdM activities. Many people, some participants report, do not attend meetings because the village chief is there. Sometimes communities are scared to express themselves "in the presence of wealthy people or the village chief". Conversely, in some places, people only attend if their leaders ask them to; the village chief and religious leader are therefore a real driving force behind mobilisation.

In any event, aid actors must always place themselves in the position of facilitators and create situations conducive to finding partners and fostering collective action. This entails getting involved to promote communication between partners who do not know each other and understanding how to identify and make the most of opportunities.
It also requires a sense of negotiation and an aptitude for promoting solidarity between communities sharing the same interests.
Forums for discussion such as the Dhulikel workshop are absolutely essential in order to have an exchange of views between projects and reflect on such different projects within the same organisation.

2C COMMUNITY WORKERS (COMMUNITY HEALTH RESOURCE PEOPLE, INTERMEDIARIES, WORKERS, ETC.)

It has already been pointed out that knowledge of key cultural factors is essential when working with communities. To gain access to another culture, good intermediaries within the relevant group or population are important, and one of a project's cornerstones is the participation of **resource people** and intermediaries.

They are a key factor in integrating projects into society as well as encouraging the empowerment and the participation of local populations. Community workers, who serve as real bridges between communities and the project, strengthen and expand the existing health services, enabling them to reach more inaccessible (during armed conflicts, for example) or more vulnerable populations. For NGOs such as MdM, they operate at the intersection of biomedical and local traditional systems, they are familiar with local cultural representations and practices, and serve as a gateway to the medical world.

Yet this intermediate position, usually voluntary, creates ambiguity due to poor living conditions (can we expect the poorest people to commit to volunteering?) as well as issues of comprehension and communication. Community workers often face the same social, family and religious hurdles as the rest of the population. In one project, one of the best- trained female workers had to drop out because her husband felt she was not spending enough time at home. In another, workers had to cut short their activities due to political and religious

MEDECINS DU MONDE
PYAPON, PROJECT
MEDECINS DU MONDE

conflicts that sidelined them and deprived them of their position as representatives. And in other projects, some workers leave to find seasonal employment.

1 / DIVERSITY OF FUNCTIONS AND DESIGNATIONS

Several terms are used to designate those working with the community on promoting health, harm reduction, raising awareness, and so on. A "community health worker" (CHW) is the general term. First appearing in 1978 in the Alma-Ata Declaration adopted by many governments and NGOs, it specified that CHWs must meet a certain number of criteria[48]: they must be members of the community, chosen by the community and accountable to the community for their activities, and they must be given training. In 1989, the WHO recognised that the CHWs could have an impact on health indicators and reduce death rates. CHWs now have different titles depending on the country and project; these include community health worker, village health worker, community worker, facilitator, mediator, resource person and intermediary.

Similar to the wide range of projects and actions, community workers can also take on a variety of activities. Lehman, Friedman and Sanders propose a simple distinction between a "generalist CHW" and a "specialist CHW". There are many examples of projects based on so-called "specialist" CHWs, mainly in the fields of maternal and infant health, reproductive health, nutrition, malaria and, more recently, HIV/AIDS treatment.[49]

Most of CHWs' time spent on community projects is devoted to prevention and health promotion, with activities as varied as hygiene and sanitation, vaccination, monitoring and nutritional advice, family planning, birth and death registrations, disinfection, first aid, and basic treatment for common diseases such as malaria, diarrhoea and acute respiratory infections.

In terms of delegating tasks, the WHO recommends calling on CHWs for patient follow-up. Workers must be able to identify basic symptoms and make a medical referral. They can dress wounds and sometimes give subcutaneous and intramuscular injections and play a role in providing long-term treatment and contraceptives. The prerequisites are therefore relevant prior training and close supervision by the care providers. But as we will see below, the disparate levels of qualification of the community workers make it hard to standardise activities within the same project.

2 / SOCIO-CULTURAL PROXIMITY AS COMMON CRITERIA FOR SELECTING COMMUNITY HEALTH WORKERS

Proximity and mobility are two key characteristics in the work carried out by community workers. They allow them to make home-visits to patients or care for them in accessible locations, such as the village square, a community centre or the courtyard of a housing compound. They mean the CHWs are able to understand their patients' preoccupations, and the local population can immediately identify the workers and include them in their networks.

This position, however, is not automatically representative. An individual cannot represent a whole community because a group is heterogeneous by nature. A person may also be part of latent conflicts, opposing groups and so on. On the other hand, people from outside the community may be more impartial as they do not inherit past conflicts, they can bring a fresh perspective and may be more objective and less emotionally involved. But the group may be more hesitant to speak openly about its needs and concerns with someone seen as coming from "afar". Moreover, the acquisition of CHW status, perceived as a social promotion, distances the workers from traditional practices, which they now view as obsolete, and leads them to disavow such practices.

"People in my neighbourhood are archaic. They act like old people; they haven't changed and they don't understand that you have to change. [...] As for me, I was chosen, I had training and now I can explain things to them…".
A worker who had been trained in health education[50]

Aside from these reservations, having a worker who is close in culture, social factors, gender, age and other characteristics fosters a good fit between activities and community realities. Choosing the right workers, for example, makes it easier to tailor the message during awareness-raising sessions by basing information and practices on aspects of their own experience. This allows both the project and populations to find meaning in recommendations that are sometimes based on behaviour far removed from the local cultural environment and its usual ways of living and behaving. The message must be adapted so that it can be put into practice, especially if the message was developed far from the local setting in which it is being implemented. This can be the role of community workers and peer educators.

Because the CHWs have a direct link with the projects, their socio-cultural position influences the population's perception of the activities. Their current or previous status, gender, age, experience, roles and responsibilities are important. CHWs are not neutral; they have a certain identity that needs to be taken into account because their identity influences the participatory process.

"During a training workshop on participatory methods in Liberia, many of the attendees turned out to be former teachers and were known as such by the population. This affected their behaviour in that they tried to reproduce the top-down teacher-student relationship in their interaction with the population. Similarly, the behaviour of some members of the population was influenced by the deference they showed towards people they had known as teachers and who represented a certain intellectual elite."[51]

48. Marie-Agnès Marchais, community health worker study, S2AP, 2009.
49. U. Lehmann, I. Friedman, D. Sanders, "Review of the utilisation and effectiveness of community-based health workers in Africa." Joint Learning Initiative: Human Resources for Health and Development, 2004.
50. M. Bouchon, Internal evaluation mission report by the S2AP, Niger Action Advocacy Research project, MdM, Feb. 2010.
51. URD, "Manuel de la participation à l'usage des acteurs humanitaires. Pour une meilleure implication des populations affectées par une crise dans la réponse humanitaire." [Participation manual for humanitarian workers. For greater involvement by populations affected by a crisis in humanitarian aid] URD & ALNAP, 2009.

3 / THE WORK OF COMMUNITY WORKERS: LIMITATIONS AND ISSUES

The difficulties reported by community workers on the ground are wide-ranging in nature. They include:

→ **Isolation:** poor road infrastructure and inadequate transport and communications.

→ **Limited technical skills:** the low literacy level often hinders comprehension of training, procedures and work standards, especially if they are not appropriately tailored to the worker. This requires better project supervision by the teams to address these issues.

> **"Really, intermediaries have a lot of shortcomings. They may not have had enough training in the best methods for approaching and educating people, and they don't always know how to talk to them. Wise decisions need to be taken about training intermediaries. MdM undoubtedly has the resources to train them. Not having sufficient pedagogical skills affects their motivation."**

These remarks by a village chief also raise the question of workers' motivations and rewards. What is their incentive for participating in these activities? What do they receive in exchange for their time? How can the most vulnerable populations remain involved?

→ **A lack of credibility with the community:** CHWs sometimes work with populations who either have little interest in their efforts or lose interest over time because they do not view the worker's role as essential to managing their health. It is not rare in the middle of a project for a worker to have to propose two or three dates before managing to get people together for an education session.

> **"You have to be patient when you're an intermediary; people don't come for a chat. [...] It's tiring, especially when you're not paid for it and people don't show up. If I don't make any money, is it worth getting people together to tell them things?"**

→ **A lack of credibility with professionals:** health professionals and administrative personnel tend to play down the role played by CHWs or consider them as yet one more burden to manage during projects. Workers may be seen as "imposed" by health projects decided without input from health professionals, who then have trouble including them in their procedures. CHWs involved in projects may then feel uncomfortable with these professionals (especially if the latter look down on their role); they may be fearful of speaking out, of appearing to show disrespect and of coming across as ignorant, while not daring to contradict. Creating a climate of trust among all project members is vital.

→ **Jealousy and pressure from other community members** caused by the power (status/training/responsibility) that CHWs' status gives them or the resources made available to them, such as a computer, petrol, daily allowance, etc.

> **"It's not easy. The people in my village think that because I work for an NGO, I want to be like the whites, and they also think I'm going to get rich. They ask me for things."**

→ **Possible mismatch between CHWs' activities and community expectations** – for example, village residents who want curative care rather than preventive action. This especially holds true if communities are disappointed due to problems with certain projects, such as shortages of essential drugs, thus reducing the value and impact of workers, who then find themselves underutilised.

→ **Conflicts of interest reinforced by the projects:** projects sometimes take place in communities that can be viewed as local arenas where various strategic groups[52] compete. Because in a community not everyone has the same interests and challenges, individual rivalries and personal disputes and antagonisms that cause rifts in a project must be taken into account. Activities come up against many power plays, such as workers' use of their new status for personal ends, or the redirection of project-related resources, such as the use of facilities for other purposes. At the same time, projects can generate conflict among CHWs based on the relative positions they hold. In a worst-case scenario, projects endowed with significant resources turn community workers into simple service providers (CHWs who work for projects rather than their community).
The sources of difficulty include:

– recruitment of CHWs: due to their good relationships in the neighbourhood or village and with the government and/or local authorities, people are selected to become community workers, thus indirectly increasing their personal power in the neighbourhood. In some cases, they may even use their power to run for local political office. They must then return the favour to those who helped them achieve this status;

– material resources that strengthen a social group's power (acquisition of a facility for an association, for example). This involves a specific rationale for various prerogatives and privileges, one of the most notable being a vehicle;

– the problem of incentive bonuses and misappropriation: by being associated with an NGO, community workers may feel the need to demonstrate or justify the value of their social position to the rest of the group. This sometimes takes the form of their ability to redistribute project resources (incentive bonuses, for example). If their ability to redistribute is inadequate, i.e., if they have insufficient access to resources, they may look elsewhere for what the project itself does not provide. This leads to parallel practices and misappropriation of resources for the purpose of improving daily life, such as the use or resell of equipment and the like. Introducing incentive bonuses also adds an element of uncertainty to project continuity. When funding ends and puts a stop to incentive bonuses, workers may refuse to continue training or to travel. Continuing to provide incentive bonuses then becomes a major prerequisite for the long-term viability of activities and an additional constraint for which project managers must be prepared.

52. The term "strategic alliance" can be found in other documents. For more information, see **Olivier de Sardan J.-P.**, 1995, *Anthropologie et développement. Essai en socio-anthropologie du changement social* [Anthropology and Development. Essay on the Anthropology of Social Change], Paris, Karthala.

→ **Danger, pure and simple:** the participation of CHWs in a sensitive project can create risks for their, and the population's, security. In Niger, those working for family planning projects in areas where the issue is taboo talk about their problems educating women in safety:

> "For single and younger women, it's in secret, it's too dangerous, they are a target population we can't educate. They wonder why we're coming to see them; they say: but what will people think if you come to see me?"

The possibility that workers will be seen as "inciting debauchery" can influence the selection criteria.

> "If we decide to use unmarried workers, the authorities will say that we're inciting debauchery. We can't do peer education for single women."

Women who work in projects fighting violence against women also indirectly increase their risk of being victimised and stigmatised. And in communities where they have very little power, where they are not allowed to participate in public activities, it can be complicated to have them take part in projects without running the risk of marginalising them.

The project must be culturally adapted to the woman's position in society; for example, the men have to understand why the women should be included in the participatory project. In Papua, for example, healthcare is socio-culturally men's responsibility and women be put as serious risk by being involved.[53] And in conflict situations, women who have been victims of violence could be in danger if confidentiality is not maintained. Sensitive information must only be collected if structures and a process are set up for protecting such data.[54]

→ **Political and religious pressure:** in certain projects, including harm reduction among people practicing criminalised or stigmatised behaviours, such as drug use and prostitution, peer educators are soon exposed to harassment by the police and institutions. In the case of French programmes working mainly with marginalised and excluded populations in precarious administrative, stigmatised and criminalised situations, recruiting people in the community exposes them even more (the intermediaries are more easily identified by the police or institutions). They may be pressured or harassed (to provide information, to intimidate them and make them give up their role, etc.).

4 / SELECTING COMMUNITY WORKERS

Choosing community workers is a key step that greatly influences the success of a project. There are two stages: criteria setting (short-listing) and the actual selection. Communities play an essential role in this process. Depending on the context and project, the selection is either made by village health committees, if they exist, during assemblies bringing together the whole village, by village chiefs and religious leaders or by the health district managers.

The criteria for selecting workers are based on the type of beneficiaries, socio-cultural determinants, the project's objectives and activities, and age, gender and language issues. In a project seeking to reduce maternal and infant mortality, gender and age are obviously particularly important to lend it greater legitimacy. In many societies, the participation of women is only possible if the health personnel are women themselves. Community workers are not neutral; they bring their own perceptions and views of the project even if they are problematic, which forces projects to make compromises and work around their objectives.

EXAMPLES OF SELECTION CRITERIA BROUGHT UP DURING THE DHULIKEL WORKSHOP:

- **the person must have experience with the specific issue, i.e., someone who has gone through what the people will go through or are going through: for example, women who promote exclusive breastfeeding should be women who have breastfed their own infants; women who talk about prevention methods with clients should be those who were sex workers;**
- **the person must be motivated (even though it is not always easy to define or interpret the word "motivated", especially in intercultural situations);**
- **the person must have enough self-confidence to speak to others, both individually and to a group.**

The influence exercised by leaders and the community in choosing CHWs is not without its own problems. These are related to strategies, networks, disputes and suspicion – for example, national personnel, who often know the population and their areas of operation well and who are neither fooled by, nor naïve about, the selection methods.

> "In fact, it's not really the community that chooses; it's the village chief who often chooses his family. We don't always get to choose the intermediaries; we accept the chief's decision."

The village assembly system does not always turn out to be an effective way to avoid the more traditional selection methods, i.e., imposed by leaders:

> "It's not obvious an assembly is the best choice; the chief can influence the assembly as well."

Another bias: the community often selects CHWs who have already worked with NGOs or international agencies. This previous experience naturally singles them out, even if they were not particularly effective:

> "They recommend people who are already used to working with projects; this was taken into account during the selection process, so we were careful".

For all these reasons, there is cause to look at the limitations and pitfalls of community participation. Aren't projects fabricating jobs and new job communities built around health projects, with workers who may be coming on board more for the job than for the well-being of their community? If the project system is organised from the outset with workers who have no real credibility, it will be very difficult for them to operate socially within their community and continue their activities. An unintended result is that workers feel more connected to the NGO than to

53. **Marie-Agnès Marchais,** study of community health workers, *op. cit.*
54. See "Pour une éthique de terrain. Gestion des données personnelles sensibles (santé – histoires de vie)" [Field work ethics. Management of sensitive personal data] (health – life stories)], MdM, 2010.

their community during activities, quite simply because it is the project that has placed them in their role rather than the community. Here, too, it may be possible to overcome this difficulty if the project has forged solid ties with the health services so they can continue to include the CHWs in a team and, therefore, in a project.

As a result, the system set up by a State's community health policy must be considered when selecting CHWs.

"We need to work in close cooperation with the health services because they might continue operating afterward. We don't necessarily need to use other intermediaries, but can rely on those who were already in place; if not, those selected only for the project will stop working when it ends, while those already working with the different structures will continue even after the NGO leaves."

In addition to the difficulty of identifying current workers, projects might have selection criteria that differ from the qualifications of the State's workers. It is worth considering, however, whether it may not be preferable to take on workers who are already part of the health system, since working with new CHWs raises the issue of their job security.

Lastly, the scarcity or lack of availability of people who meet the rigorous selection criteria needs to be pointed out.

"What with the rural exodus and work in the fields, there aren't many people available. We look for available people and they're not always the best ones for the job. The level of education restricts our choices because in a village there might not be a single person who knows how to read or write, so that skews our decision. We had to find someone who knew how to write in Arabic, but even that was difficult."

The education-level criterion may thus be lowered, resulting in a "default" selection that makes it harder to train workers and therefore their understanding of the activities they go on to undertake.

"The problem is with training. There are workers who don't learn anything. They can't write and remembering everything from the training is hard!"

These selection problems affect the credibility of the selected workers. Knowing their past is key to understanding how the project will be viewed by the community.

"The assembly always chooses old women because they're available, but that doesn't work when you're talking about family planning to young women. Young women don't want to talk to old women; they're embarrassed. And husbands of young women don't want them to be intermediaries, especially because they'd be volunteers and they don't have time. Old women are more available, that's all. […] You have to pay attention to age because a young woman doesn't want to talk about these things with an older woman and vice versa. In addition, the old women have never used family planning and won't ever use it, so they can't really explain it; you would need a young woman who's using it at the moment. On the other hand, the old women are more discreet than the young ones!"

The intermediary's attitudes can influence the smooth functioning of activities and acceptance of the project. This is the process of social influence, which is related to concepts such as education, emulation, conformity, conditioning, obedience, accommodation, leadership and persuasion. Social influence is normative influence, leading individuals to conform to others' expectations out of fear of social "punishment", such as rejection, hostility and isolation. Women attending awareness-raising sessions are sometimes accused of wanting to live like Europeans.

5 / THE QUESTION OF **COMMITMENT, MOTIVATION** AND **REMUNERATION**

"Ultimately this is a full-time job, because even when you're out in the fields, people come looking for you."
A community intermediary

Participating in a project requires committing time – meetings, training, meeting with beneficiaries, round-the-clock availability, etc. This needs to be taken into account when planning activities so that people who want to get involved do not get into difficulty with their workload or schedule and so on. Especially since the time spent on these activities is time not devoted to other ones:

"CHWs have a time problem, an availability problem. They might go out to the bush, to their fields, and not necessarily have time to talk. If people come to them once and they're not there, and they come back a second time and they're still not there, they get discouraged. But the CHW can't just stop working in the fields."

So we have to distinguish between a one-hour a week community commitment and a daily commitment. At any rate, we must make sure not to ask too much of community workers in terms of time and responsibilities, because their economic (and administrative) situations are also, by definition, insecure. This may mean establishing guidelines right from the start that define the roles, duties and commitment limits of community health workers. These guidelines could serve as safeguards essential to preserving the balance for community health workers in order not to disrupt their social and economic lives.

The ethical debate on voluntary work, compensation and remuneration comes up in many MdM projects. It is an issue in the Lotus Bus project, where female sex workers who have another professional activity take the time to help the bus teams talk to other Chinese sex workers. The time they give is time that they do not use to look for customers, or quite simply to work, though they have already difficulty in finding enough paid work to meet their basic needs or repay the debt they incurred to come to France. While the pertinence of using CHWs is no longer in question, the issue of remuneration remains central to their continued role, and can hardly be completely divorced from that of motivation.

What motivates community players is not always what the aid and development actors expect; in the minds of the latter, there are three reasons for participation: learning, empowerment and contacts. Participation should, after all, allow projects to have CHWs interfacing with the whole population.

The two groups' expectations are fairly contradictory, and success in meeting one group's expectations often means not meeting the other's. Thus CHWs – who project teams like to see as "democratically chosen representatives of the population" – often appear to other community members as "project people" who manage to "eat" thanks to the project. Yet frequently the project doesn't "give" anything. Most community health workers are volunteers, generally only compensated for transportation and food costs. This often goes down badly not only with the CHWs, but also with the community:

"People tell the CHWs that it's useless work because they're not paid. The CHWs could have credibility if they were paid in addition to being trained. Everyone knows that everybody should be paid for work. […] People also need to see that there are CHWs in all the villages, that it's something that's taken seriously."[55]

Volunteer status also has the perverse effect of making the activities less credible.

"People don't always understand what we do. In the beginning, people laughed in our faces because we took a job where we didn't earn anything."[56]

Admittedly, the CHWs may receive in-kind benefits (pagnes or T-shirts, for example), as well as compensation during training.

"These are motivational strategies, and they work. But they're not enough. Even if all the intermediaries are dressed in project pagnes, it's not enough."[57]

The issue of the relationship to money and remuneration/compensation is complex, a source of controversy and generates tension, and we are not always able to sort out what is down to differences in culture or character or simply to the degree of economic insecurity in the area in question. As one Nigerien participant at the Dhulikel workshop noted, motivation, remuneration and recognition are often intertwined.[58] The ambiguity of the words reveals the importance of these issues. Of course, people can, independent of remuneration, find significant benefits (recognition, elements of power) to their participation. There may be significant rewards in terms of improved social status, recognition, learning, freedom, and new forums for expression – especially for women. One Vietnamese woman participant added that for people who have been through very difficult ordeals, volunteer involvement can be an opportunity for personal healing.

55. 56. 57. M. Bouchon, Internal Evaluation Mission Report, op.cit.
58. "We say to people, you're volunteers, but you'll get motivation. In Abalak, in a small family grouping, we started to introduce ourselves to the chief of the village and talked about motivation. The chief welcomed us with open arms. After a few work sessions, "the motivation" hadn't come. One day we found ourselves all alone, with no chief but with a few people who were used to coming to the meetings. But we were told that the chief had something else to do, and wasn't coming."

The main motivations cited by community health workers are:

- Recognition within the community of their role, which engenders pride and the feeling of having more power within their community. "The fact that people come and ask for our help…that's our motivation. They see that we're capable of saying what's okay or not, and that motivates us and it's good. Even people from other villages ask for our help."[59]
- The symbolic value of being part of another community (the community of MdM project operators, or that of other CHWs, etc.) – in other words, belonging to a project. The CHWs appreciate that their activity is being followed-up by the facilitators, the health facilities, and the people from the project:

**"I'm proud when I see the Médecins du Monde car arrive in the village and it's us they talk to, not the other people. We go home and put on our uniform."
One community worker[60].**

Note that the uniform is particularly appreciated, because it's a reminder that they belong to the project and sets them apart. It affords a certain respect.

- The opportunity provided by training to improve their knowledge, social capital, and power within their community:
- Greater freedom, thanks to new forums for expression.
- The opportunity and desire to change things, for their community's well-being, health, and rights.
- The opportunity for personal healing, and to have a future to look forward to, thanks to the battle to be fought.

While some workers are remunerated in very specific projects, this can have perverse effects. In Myanmar for example, CHWs are officially volunteers, despite spending a lot of time on activities. As they sometimes make as many as fifty family-visits a month in the villages (as much time as they do not spend working or looking for work), satisfied families give a sort of compensation for the time they spend in the community. The families consider that it is cheaper to give the workers a little money than to travel to the nearest health facility or pay for more expensive care due to the time it takes to be referred. In other contexts, it's not always so simple. As the president of a Nigerien partner association put it:

"The workers are doing this, although they could be doing something else to get food. I understand that they expect something in return. But we need to give this some thought. We can't give too much incentive, I don't think, because it stirs up trouble and puts people in a difficult position; there can be problems between the leader and the workers, people will be uncomfortable. I remember there was an NGO that gave bonuses according to the number of sessions that were held. The workers would get to the end of the month with reports of twenty, thirty sessions, and it was a problem. To get money, they could have reported a hundred sessions! It's good to give people something, but what? Rewarding performance isn't bad, but it's unfair; if the worker is sick, they get nothing. I think further training might be the best option."[61]

59. 60. 61. M. Bouchon, internal evaluation mission report, *op.cit.*

Also, how can we remunerate CHWs without compromising the sustainability of a project? The communities will not necessarily have the means or the inclination to continue paying them later on. We could possibly set up a roundtable system at the start of a project with the partners, the authorities, the community and the CHWs to discuss these remuneration issues:

> **"We shouldn't pay salaries," continued the partner association president, "but support the workers, see how we can reward them, ask them how they see their rewards. It has to be people we work with all the time, but finding the right mechanism is difficult. That process can be done with individuals, we can also choose intermediaries with regard to those rewards. At the moment we work with what we've got, workers who are competent or incompetent, some of them we see more often. It takes a day or two to get them together, but it's possible to do something to find a solution. […] An intermediary, by definition, is a spokesperson who has to be committed, has to understand the project philosophy. […] But volunteering is when someone has the means. Someone who works for 100 Fr. a day can't be a volunteer. Intermediaries should be the cornerstones of the project, because they're the link to the whole community. So it's really important that they have high-level involvement, so how do we find a system of motivation, of bonuses, even selective? Perhaps more training, a small salary, a way to make up for those hours on the project, some compensation."**

The principle of voluntary work in settings of great economic insecurity is a difficult one.[62] As a result, the projects' "participatory" ideology, according to which work provided for free by the population is a guarantee of their interest and constitutes their contribution, increasingly runs up against the representations and strategies of populations who believe that projects have resources, and are a means for the teams to get rich "off their backs". So they also believe that they should get their share of compensation, per diem allowances or other direct forms of remuneration.

6 / THE ISSUE OF INITIAL AND FURTHER **TRAINING, FOLLOW-UP** AND **SUPERVISION**

While training allows CHWs to enrich their knowledge, it also fosters an environment conducive to the success of the project, because it reinforces motivation and the feeling of belonging to a work team. "Being part of a team" is one of the motivations cited by workers, because further training and follow-up make these workers "exist" in the eyes of their communities and the aid and development actors.

By its very nature, voluntary work can often lead to feelings of isolation and frustration. A lack of support or supervision may be perceived as a lack of confidence in their ability to participate in the project. We have to sustain their interest in participating by also allowing them to make decisions about the process. Good supervision and support can reduce or eliminate such frustrations. Follow-up can be handled by the project team or by the community, via village committees, for example. At regular follow-up meetings, community workers should be encouraged to express the problems they encounter in their work without fear of judgment. These meetings can take place with the help of someone from outside the team who reminds them that the meetings are confidential so that CHWs will not be afraid to talk about management issues. They should be given feedback that not only recognises their work, but also shows that their problems have been heard and taken into account.

We also have to be able to offer other trainings on a regular basis, especially since the initial training period is often too short for them to take everything in:

> **"During training," describes one member of the MdM team, "we only train the intermediaries in the basics, that is, referrals. We also need to work more downstream, in further training, to maintain a level of knowledge and understand how the intermediaries see their training. We must o check whether they've understood everything, because if an intermediary refers a child to a health facility 20 kilometres away and the child doesn't have a problem, is the mother going to do it again? People are going to say, 'we knew that intermediary didn't know anything."[63]**

The sustainability of CHW activities depends largely on follow-up and supervision.

Supervision confers a feeling of self-worth and recognition, especially for CHWs who are isolated and have little contact with other CHWs or even the project team. Ideally, supervision is the formal HR management tool for remedying weaknesses, encouraging good practices and helping to improve individual and group functioning.[64]

Joint training helps reinforce the "team" aspect that motivates CHWs, and could be extended to other subjects in order to broaden the CHWs' skills. But training has to be tailored to both the reality of the situation and the abilities of the CHWs being trained. Training content can sometimes be inappropriate to the context in which the CHWs find themselves, leading to a discrepancy between the best practices message and what is actually possible for the population. Training content must therefore be specific and take the skill level of the CHWs into account (avoiding technical jargon, for example).

The problem of follow-up is a reality that has to be addressed with populations; for example, when transferring the project to partner organisations and the sustainability of the CHWs' functions after the transfer. Yet we have to find a way to integrate community intermediaries for future activities:

> **"Train the community intermediaries just like us; we're in the bush, nobody's talking about new things! We could train together."**

62. Some projects may have a system where the CHWs/peer educators are compensated or receive some compensation if they work over a certain number of hours.

63. M. Bouchon, internal evaluation mission report, *op.cit.*
64. Marie Agnès Marchais, study on community health workers, *op. cit.*

7 / ROLES APART: PEER EDUCATORS AND TRADITIONAL HEALTH PRACTITIONERS

Peer educators

Peer Educator and Peer Social Worker are just some examples of what we call people with first-hand knowledge of a target community's practices: for example, a person living with HIV/Aids talking to other people with HIV/Aids; a drug user or former drug user talking to drug users; or a sex workers talking to other sex workers.
A project working with peers recognises and believes that such people have skills and knowledge to share. In many countries drugs users, for example, have worked for decades as volunteers to improve their health and fight for their rights. Their effectiveness is due, to drug users being more likely to listen to harm reduction advice coming from people who don't "judge" them for their practices – as they suspect health professionals do – and who are empirical experts, as it were, on the issue. For the projects, peers offer direct access to valuable knowledge on the needs and practices of target populations; they know the types of drugs and the risks of this or that practice, and may have developed their own ingenious strategies – strategies that, because they are more realistic in the context, may be more pertinent than those of the health professionals. For many, peer action is a first big step toward stabilising and improving their socio-economic and environmental situation. This contributes to self-esteem, empowerment, and a health promotion approach.

Working in community projects bolsters the feeling of belonging to a group and helps create a community of rights. When people feel part of a group, they feel more responsible toward the group, and curb their antisocial or violent behaviour. Working with peer educators contributes to their civic involvement and political responsibility. As a result of marginalisation and stigmatisation, drug users, for example, are often excluded from the political decision-making process, even though this can have a serious impact on their lives. Working with peer educators allows a better understanding of the issues, and thus policies that are better-adapted and better able to effect change.

However, for these people – who are often engaged in illegal activities – confidentiality is a sensitive issue. Public information must be shared carefully, and people allowed to decide whether or not to make their personal information public. Drug users face numerous obstacles in the workplace, for example, and may fall victim to police persecution. Drug use puts users at frequent risk of arrest or police harassment. The fear of reprisals or penalties often discourages them from seeking advice. So before looking for peers, we have to create a favourable – that is, safe – environment.

A number of questions were raised during the Dhulikel workshop about the ambiguity of the position of these players:

- → What is their place in the community when they have another status (in addition to that of MdM peer worker)? Are peers still members of the community when they become a member of MdM, remunerated or compensated for their work?
- → Do the same rules that apply to other people working for MdM apply to peer educators?
- → Conversely, do the rules for programme users apply in the same way to those who become members (punctuality, internal regulations, etc.)?
- → What is the peer educator's position with respect to the rest of the volunteer team (a fundamental question for programmes in France)? Do they become volunteers on an equal footing with the other volunteers (eligible to become a member, head of mission, etc.)? If they do, how are they going to manage their position within the community, if they are also in the NGO? This presupposes that they have to respect the association's ethical and moral principles, and its rules, just like the other volunteers.
- → Professional confidentiality, for example, is a crucial issue.
- → What can go wrong, and what are the means we can implement to prevent that happening (training, debriefing, personalized follow-up, etc.)?
- → What are the selection criteria for recruiting peer educators? Belonging to a "vulnerable group", which allows not only better access to the population but also has a greater impact? Personal experience of the practice itself, like projects with sex workers? This is the first selection criterion for a peer educator, even before language or region of origin. Indeed, even if the "beneficiary population" is migrant women who don't speak French, the common language is really that of a particular practice (on the streets, in the massage parlours, in the hostess bars, etc.), and above all, experience with customers and the police.

In summary, the involvement of peer educators in projects allows:
- **→ better inside knowledge of target groups, thanks to peers' experience and expertise;**
- **→ better access to the target group;**
- **→ more effective interventions and greater project credibility;**
- **→ better ownership of and participation in the project;**
- **→ greater self-reliance;**
- **→ the principle of equality and reciprocity to be integrated into projects.**

Traditional healers

Relationships with traditional health practitioners have become an ideological and political issue over the past two decades.[65] After the WHO's efforts to integrate traditional medicine into primary health care in the late 1970s,[66] we are seeing these players being integrated into healthcare projects.

Who are they, these "traditional healers" who draw their knowledge both from tradition (pharmacopoeia, essentially) and modernity, employing the anatomical and physiopathological vocabulary of modern medicine and allopathic treatments? The practices of these specialists are not static, but evolving, making traditional medicine a heterogeneous and changing assortment of practices and knowledge. Medical knowledge – that is, the ability to recognise, explain, and treat disease – is only one of the aspects of a general knowledge of life and the world, just as divining and healing powers are.

They are not just "healers". Their learning and skills may stray from medical knowledge, but this does not mean they are not specialists. There are healers who only treat eye infections using licking, and therapists who just treat broken bones. But such knowledge is almost always part of a broader body of knowledge used for purposes other than treatment. Conversely, there are men and women who reserve their knowledge of disease for personal and domestic use, and who are not called healers by people in the village. What they do have in common with healers is that the group recognises their ability and legitimacy (if not, they are called "charlatans"). This recognition of someone's

65. D. Fassin, ***Les enjeux politiques de la santé*** [The political challenges of health], Karthala, Paris, 2000.
66. *Ibid.*

ability and legitimacy to intervene during an illness is essential to the treatment process. They allow therapists to treat and are the basis of their prestige. They are able to cure because they have power, and the group gives them power and the right to practice because they know how to cure.

That said, their power is not confined to the medical domain. Recognising traditional healers as CHWs has its own risks – for example, the risk that they will use their new-found status to increase their power or make people pay for their services.

Traditional birth attendants[67]

There are many terms used to designate these traditional perinatal care specialists: *matrones, dais, comadronas, ambuya, hilot,* etc. To cover all of these individuals who have a very wide range of practices, the WHO has opted for the generic term "traditional birth attendant" – a term defined in contrast to that of "skilled attendant", who is a health professional.

The traditional birth attendant usually practices in rural settings, in her own and neighbouring villages. She may also offer other kinds of traditional care (the *matrones* in Madagascar are also called *masseuses*, and can massage not only women and children, but men too). Depending on the society, they may be recognised as an official *matrone*, but then again, they may well not have any particular status and attend women more by necessity than by vocation, because they live nearby or are experienced. They are a heterogeneous group – a traditional birth attendant can as easily be an elderly woman who has had several children as a young woman who was trained by an older one. Usually illiterate, she hasn't had any formal training, and her practices are consistent with the beliefs and values of her community. She plays primarily a support role, but may also be responsible for monitoring the pregnant woman or the infant, or have a role similar to that of a healer (the traditional birth attendant is sometimes a herbalist).

In the 1970s, the WHO began actively encouraging countries to train their traditional birth attendants and integrate them into their health care systems.[68] The problem is that the WHO's determination often pushed NGOs and governments to find traditional birth attendants in places where they did not exist. The training of women who fit the concept but who were not really recognised by the community for that specific role may have been partly responsible for the failure of some projects. In the 1990s, though most developing countries had set up programmes to train traditional birth attendants, the long-term impact on maternal mortality was below expectations. The WHO's enthusiasm for encouraging training for traditional birth attendants has waned, and the strategy is gradually being abandoned.

67. Julie Bouscaillou, study on traditional birth attendants, S2AP, 2009
68. WHO, *The Traditional Birth Attendant in Maternal and Child Health and Family Planning,* §9. Conclusions and Problems for Future Investigation, pp. 84-85, 1975.

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KNOWLEDGE TO BE ABLE TO ACT

This third section presents a range of analytical tools to understand the context of a project based on practical experience. It emphasises the need to analyse the context and more particularly the socio-cultural factors that are often overlooked in classic analyses. It does not cover all the steps in project planning, as these will be examined in a separate guide.[69]

69. *Guide de planification de projets de santé* [Guide to health project planning], MdM, Paris, to be published in 2012.

3A

TYPOLOGY AND ANALYSIS OF COMMUNITY ACTIONS

1 / A NON-EXHAUSTIVE LIST

Here we will give an outline of community actions in solidarity, health and social projects; these cover a broad range with very varied practices.

According to B. Goudet,[70] a typology based on the initiative of action allows different practices to be identified – from those where the initiative is taken by professionals and institutions, to those where it is taken by the people actually affected by a situation. Implementation of these different forms of participation depends on the organisation, the setting and the stages of the project.

For the many different reasons that we gave in the chapter looking at the complexities of working with communities, it is common practice to consult populations in the highly participative diagnosis phase. However, it is much more unusual to consult them during the programme design phase, and they are often far less involved in follow-up and evaluation. And, support for local initiatives is still insufficient in the humanitarian sector. Furthermore, as already mentioned, an unintended consequence of this lack of support for pre-existing initiatives by some projects is that they end up somewhat diminished through having to compete with the implementation of comparable and non-integrating projects. This is one of the worst-case scenarios.

The different community approaches can also be classified by:

- → domain (water, nutrition, sanitation, communicable diseases, etc.)
- → population (villagers, women, sex workers, etc.)
- → location (village, neighbourhood, school, prison, etc.)

Using this structure, Médecins du Monde has:

- → projects involving populations in risk and disaster management, mental healthcare, access to primary healthcare, harm reduction related to substance abuse and sexual practices, reproductive healthcare, advocacy, the fight against the major epidemics (HIV/AIDS, malaria, tuberculosis), human trafficking and gender-based violence, nutrition, microcredit, etc.;
- → operations involving villagers, pregnant women, women victims of violence, traditional healthcare providers, high school students, religious leaders, migrants, sex workers, drug users, street children, displaced people, etc.;
- → actions in rural communities, urban neighbourhoods, slums, factories, high schools, in front of places of worship, health centres, organisations, prisons, etc.

70. **B. Goudet,** *Développer des pratiques communautaires en santé et développement local* [Developing community health and local development practices], Chronique Sociale, Lyon, 2009.

2 / COMMUNITY PRACTICES IN DIFFERENT SETTINGS: VILLAGES, SCHOOLS, ETC.

It is quite common to find community actions in villages and neighbourhoods, classic representations of the clearly-demarcated, geographical community. Residents can raise any problems they have, hold meetings and set up associations. Or, on the initiative of outside aid and development actors, a group of residents can be helped to get organised and involved in a specific programme. This is the case of many village communities who carry out voluntary activities such as managing a community health or microcredit centre.

Schools can be good places to develop community action projects, particularly in health promotion. The network of health promoting schools set up by the WHO is one example. For such a school to work, involvement of all the different parties – teachers, administrative staff, students and their parents – is crucial. However, this type of project does not work in every culture. Even leaving aside the low numbers of children attending school, it must be remembered that in many cultures they have no legitimacy, and no real right to speak out, either in the community or in the family. So it would be a mistake to develop a programme where broadcasters with no legitimacy, that is the children, would be the agents of health promoting messages for the community.

Healthcare in prisons is often a real issue. Community actions can afford easier and more regular access to prisoners and allow aid workers to address the issue of how to improve conditions. So, the aim here is to try and integrate prisoners and prison personnel (administrative staff, guards, etc.) into projects. However, improvement in conditions for prisoners must go hand in hand with advances in the guards' working conditions and access to healthcare, as their situations are equally insecure.

More and more is being done in hospitals to protect patients' rights and to allow them to speak out directly or indirectly. Implementing community actions in hospitals is no easy task because of how long patients stay; long-stay institutions such as rehabilitation centres are more suited to the community approach. Working on health education using focus group techniques based on speaking out and the expression of representations can facilitate patient involvement and give them back some measure of control over their health.

AN EXAMPLE OF A COMMUNITY PROJECT

the disaster and risk management programme in Madagascar.

The east coast of Madagascar is regularly hit by cyclones and tropical storms and villages in low-lying land are not only affected by the damage caused by wind but also by floods triggered by tropical rain.

Studies have shown that the number of people using health facilities was low [71] and comparable to those of countries in conflict. Basic health centres, often located in a district's main town, are sometimes far from villages and hamlets where the people live. Alternatives do exist, notably traditional medicine, which is very widespread. Indeed, the majority of births occur under the supervision of a traditional birth attendant known as a "masseuse".

Madagascar has a community health policy recognised by the relevant ministerial department. This policy is supported by health committees (Cosan) at different administrative levels and by management committees (Coges) that participate in health training or even in the setting up of mutual insurance companies. On a community level, the health system would appear to conduct activities only sporadically (vaccination campaigns with the implementation of advanced strategies, mother/child weeks), or uncoordinated activities related to vertical programmes (malaria, tuberculosis, HIV/AIDS). Although MdM teams have occasionally come across such committees, there are doubts regarding their ability to operate, to carry out their role or their capacity for action.

MdM has been conducting emergency interventions in the area for twenty years now and has been piloting disaster and risk management (DRM) programmes funded by the European Union since October 2008.

These programmes have a community element with awareness raising/information-education-communication campaigns (such as the organisation of a traditional song competition and the broadcasting of video clips of the winners), training first-aid workers, supporting newly-created town committees and so on. The aim is to increase the communities' ability to deal with disaster situations themselves. It should be pointed out that this programme has conducted a participative vulnerability analysis through a series of workshops: community representatives determined themselves where their community was most vulnerable and decided on the solutions. These workshops led to the adoption of several micro-projects such as the setting up of shelters and the community management of pirogues for the evacuation of people to health centres.

In this programme, analysis of the context was fundamental. Numerous studies were carried out: map research and the history of previously affected areas, an anthropological study and a KAP survey in order to understand the areas of vulnerability and the means of resilience. The participative vulnerability analysis allowed communities to better appropriate and implement the project. It has been observed that communities are more responsive to the disaster and risk management approach after an actual disaster. So this is an ideal time to foster and drive a community effort.

71. In 2007, there were 49,592 consultations in health structures in the district of Maroantsetra, i.e., 0.21 consultations per person.

AN EXAMPLE OF MENTAL HEALTH COMMUNITY PROJECTS

A case study in the Democratic Republic of Congo (DRC) where civil society is reinventing new role models for the community

The community mental health programme and the fight against gender-based violence in North Kivu, DRC is a project to increase the skills of psychosocial counsellors. Launched in 2002, the project was based on studies and a social-anthropological watch along with a commitment to the potential of the counsellors. These are more often than not women who have themselves been subjected to sexual violence, but who have gone from victims to become actors of social change. Excluded from social networks founded on family ties due to the stigma associated with sexual violence, they turn to community solidarity. Indeed, in 2002, due to the extent of sexual violence, mechanisms for regulating social groups were gradually disappearing. This resulted in a restoration of socio-historic counselling and mediation (Mushauri and Mupatanishi).

The counsellors adapt their approach to the particular context and the socio-cultural expectations. These women identify, meet with, either individually or in groups, and listen to the victims and give them opportunities for conflict resolution that society no longer has the means of regulating. To some extent, it is a reconstruction of values. They also guide and orientate victims towards comprehensive care that caters for their medical, psychosocial, socio-economic and legal needs. And, they inform and raise awareness in communities so as to encourage better acceptance of victims and their experiences, as well as promoting the prevention of violence.

The profile of the counsellors has evolved over time. No longer former victims only, they are also local NGO activists, young people, community "mothers", men, members of religious congregations, etc. So these people offer a plethora of skills and a wealth of local knowledge based not only on experience, but also on social status. From 2003 to 2004, the counsellors were trained in client-centred therapy and counselling.

MdM's drive to increase the skills of counsellors is a community approach that serves to improve the knowledge of existing counsellors, rather than training new ones. It entailed a real consultation with the local partners and the commitment of local NGO networks. In this way, the counsellors' requests for increased skills and the transmission of knowledge and practices (in Swahili between peers in the provinces) could be properly taken into account. It also allows for the provision of long-term actions.

INFORMATION, EDUCATION AND COMMUNICATION (IEC) AND THE NECESSARY ADAPTATION OF TOOLS

The example of the Research, Action, Advocacy (RAP) project in Niger

How can we promote IEC if there is no shift towards better knowledge of the socio-cultural factors that influence behaviours?

The RAP project sought to bring about and support social change (modifying certain nutritional habits in infants, introducing family planning, etc.) particularly through "positive deviance" (an approach that helps a community and its members to find durable solutions to a problem within the community itself via intermediaries or families called "positive models"). This project has brought about a real change at both the group and individual level (knowledge, denial, acceptance, implementation of change).

The research phase (qualitative and quantitative studies) was designed, according to geographical area, to gain a better understanding of the extent of people's awareness of sexual and reproductive health (SRH) and nutrition issues, in order to be able to build upon existing knowledge. The objective of the qualitative study was to fully understand the extent of the discrepancies between tradition and custom, gauge what actually happens and what people know from awareness-raising messages on issues such as SRH and nutrition. And also to distinguish in the meaning given to the actions what was due to tradition, what was justified by tradition but linked to the social or economic situation (or vice versa). We were therefore looking for consistencies between representations and practices as well as possible discrepancies and conflicts between individuals or a person's conflicting values.

The RAP project aimed to make information on these issues available through people with a certain social status in the community (leaders) or through community workers and therefore via a network that was both "horizontal" and "vertical". Paying attention to the social networks of individuals who have either positive or negative deviant practices can help to understand the diversity of practices in terms of nutrition and SRH and the way in which these practises are or are not passed on (for example, the growing use of integrated health centres or the pill being introduced into a village).

Community and social networks can also have an influence on practices and values: we will see who the people are outside the family who influence them on these issues, either to preserve or to advance practices. Social networks can help implement strategies for innovation but can also encourage conservatism. For example, where do women get information on contraception? Is the issue of family planning taboo between women and men, with religious leaders? Is the issue of malnutrition addressed?

The project has therefore paid special attention to the adaptation of tools. Awareness-raising messages on nutrition for under five year-olds and on child spacing are broadcast through several channels: during nutritional workshops and informal discussion groups but also through plays, radio campaigns, songs and sermons.

All the community workers, "enlightening mothers", and centre volunteers have been trained to spread these messages. Workshops have brought together religious leaders and village chiefs to improve participants' knowledge, particularly men's, of child spacing, a practice authorised by Islam. These messages are relayed during sermons throughout the villages in the targeted zone.

It is always a difficult and drawn-out process; results are slow to come and are less visible to aid and development workers and beneficiaries alike. Changing behaviours takes time and the impact of IEC on a particular situation rarely shows in the short timeframe of a project. The project has endeavoured to adjust the tools to the heterogeneity of the population, even if yet further modifications are needed, especially for the nomadic population who has found it far harder to become involved. Using pictures cannot be taken for granted, as a Nigerian partner says, "We're in a society where the use of pictures is recent, I didn't know how to read a map despite being literate and having a secondary school education. I know how to find my way in the desert but I didn't know how to read a map. I had to get used to pictures, to plans, to maps. You come across project leaders who don't know how to read these plans or maps. In western countries, you live with pictures but they are recent here. Interpreting a picture is not easy, people don't read cartoons here and this has to be taken into consideration. Nobody's asked us to think about what the people are used to using and tell the people in the project. We therefore try and familiarise people with the pictures during training but it's not a natural way of communication."

Thus, a weakness in the adaptation of the tools for Touaregs who are not used to pictures was identified. They often do not understand them and look at them upside down. The project workers then have to use drawings in the sand.

This observation should remind us that it is very important for materials to be adapted to the people using them. People who do not identify with the pictures cannot be affected by the messages.[72]

72. *Health education. A pratical guide for health care projects,* MdM, 2010.

3B

PROJECT CYCLE METHODOLOGY APPLIED TO PROJECTS BASED ON COMMUNITY APPROACHES

> By clarifying the relationship between the development of community practices and the way the communities are already structured, the previous chapters have shown that any practical model developed in one place cannot be directly transferred to another without numerous adaptations and adjustments. This means that the people wanting to be part of this type of activity must first ask themselves some questions.

The challenge of such questioning, to be conducted throughout the different phases of a project, is to manage to understand the structure of a community, its perception of health and the community action projects, in order to help them better appropriate health as a common challenge and to develop projects as their own. It is necessary to co-produce knowledge by synchronising the results of studies and the objectives of any future project.

1 / ANALYSING SOCIO-CULTURAL FACTORS, AN INTEGRAL PART OF THE CONTEXT ANALYSIS

"**Health diagnosis** is the first of four phases in the **project cycle**. Its aim is to identify the public health problems of a population and the interventions needed to respond to them."[73] For Médecins du Monde, this diagnosis is a precondition to the development and implementation of any intervention. It corresponds either to the initial project diagnosis (fact-finding mission) or to a mid-term diagnosis conducted during a project after an evaluation concluding the necessity for adjustments.

The diagnosis has three stages:

→ analysis of the context or the collection and analysis of data relating to factors impacting a particular situation and its stakeholders;

→ identification, prioritisation and analysis of collective health problems;

→ identification of public health problems and possible interventions.

Listed below are the elements required to produce a socio-cultural diagnosis. However, the aim here is not to develop the whole diagnosis methodology. For this, please refer to the planning guide.[74]

Whether a community is highly hierarchical or rather more egalitarian, organised around a nuclear or extended family structure or a clan – these characteristics influence how individuals will participate in a project. In order to draw up a participation strategy and select the mediators and key people, all the social and political group dynamics must be taken into account. The objective of such a diagnosis is, therefore, to ensure a holistic approach to the composition of a community, its needs and problems.

Participation of the population at this stage can allow information to be collected quickly through the use of participative diagnosis methods. This information is often more detailed and specific than in quantitative studies and also of a better quality when it comes to developing projects adapted to local conditions.

Reminder: It must first be explained to people why and how a diagnosis is carried out, what the expectations are on both sides, how the information collected will be used, if it will be kept and who will have access to it, etc. In order to build a relationship based on trust and respect, information must be shared and transparency is required regarding goals and constraints.

In order to build up a rapport with a community with whom we wish to work it is essential to listen, ensure that those who may be impacted by any future project can express their opinions, and facilitate the expression of needs through the use of social science tools and, more specifically, qualitative methods. In reality, the increasing use of more quantitative techniques that make use of closed questionnaires only occasionally allows for a satisfactory explanation of a community's structure and the rationale behind the way in which the inhabitants live together. Diagnoses are still all too often dominated

73. *Guide de planification de projets de santé* [Guide to health project planning], MdM, Paris, to be published in 2012.
74. *Ibid.*

by technical requirements or the restrictions imposed by donors' demands. The theoretical accountability of "real needs expressed by the population" is often reduced to the overlapping of subjective perceptions: those that the population have as to what projects can offer them and those that the aid and development actors themselves have of the "target populations".

In this way, diagnoses can be based on reports and official data resulting from lightning field visits. All too often the views of local actors (particularly former community workers and traditional leaders) regarding the activities affecting them and the conditions of their implementation are either not known or not taken into account (J.P Olivier de Sardan, 1995). It is common knowledge that short-term projects influence the perception of populations: these are **"foreigners who are just passing through"**. A project that lasts three or four years is considered a "long"-term project. However, the end of a project does not mean that the conditions for its longevity sustainability at the local level have been fulfilled: on the contrary, its conclusion slowly but surely brings about an end to all activities.

In addition to the factors that define a community, the diagnosis can be organised around the following six socio-cultural dimensions[75] of the community: technology, economy, politics, institutions, values and beliefs.

Attention should be paid so as not to confuse these dimensions with the six groups of factors influencing a situation and which will be the first element of the context to be analysed in the diagnosis phase when planning a project.[76]

MdM categorises the factors influencing a situation in six groups. These are[77]:

→ demographic and health factors;
→ historical, political, regulatory and security factors;
→ geographical factors;
→ socio-economic factors;
→ socio-cultural factors;
→ factors related to health policy and the organisation of the health system.

Thus, in order to complete a full diagnosis, these groups of factors, not all of a socio-cultural nature, must also be analysed. The analysis of a community's socio-cultural dimensions will therefore supplement a wider analysis for an assessment of the overall context. Below is a series of templates for questions to be asked when conducting an analysis of a community. These lists are by no means exhaustive and must be supplemented according to the project.

Demarcation of the population in question

Who is the community I want to work with? How is it defined?

Bearing in mind that one person can belong to several communities, some aspects of the following definitions can be taken into account:

THE DEFINITION OF A COMMUNITY

→ What word is used in the local language for the notion of community? What are the literary and semantic definitions?
→ Are all the members seen as part of the community in the same geographical location? Is the notion of community linked to belonging to a specific location (village, neighbourhood, town, etc.)? Is it characterised by geographical proximity?
→ Is the community mobile?
→ Do its members regard the community as transient, short-term (students, migrants, refugees, etc.)?
→ Does the community have a functional value (religious, cultural, professional, leisure, etc.)?
→ Is the community seen as a place of mutual support?
→ How heterogeneous is the community (social class, ethnicity, values, languages, wealth, standards, etc.)?
→ Is the community recent or long-established? Are the members aware of the origins of their community? (a committed community?)
→ What are the historical references behind the creation of the community?
→ Etc.

The six socio-cultural dimensions of the community

To understand a community, it is useful to analyse the six socio-cultural dimensions mentioned above and their interrelationships.

1 / The technological dimension of a community

TOOLS, APTITUDES AND KNOWLEDGE, RELATIONSHIPS WITH THE PHYSICAL ENVIRONMENT.

This is the interface between humanity and nature. These are the acquired behaviours and ideas that allow people to be innovative, use tools and impart their knowledge.

This dimension is cultural as it is acquired rather than innate. For example, language, even though it is a vector of representations and values, belongs to the technology dimension (it is a tool). This goes hand in hand with communication and forms of communication (and therefore the media). Regarding projects, it is an important dimension to analyse.

The technological dimension of a community can be characterised by, for example, its infrastructure (public latrines, wells, roads, markets, clinics, etc.). A project encouraging a community to build new latrines can be seen as the introduction of a new technology.

In general (there are exceptions of course), sociologists view technology as the easiest of the six dimensions to generate cultural and social change: it is simpler to introduce a television than a religious belief or a set of values. However, the introduction of a new technology (if it is accepted) will lead to changes in all of the other cultural dimensions (if accepted, the construction of latrines can lead to a change in behaviours).
There are some aspects such as infrastructure, specific technologies, etc., that are not examined here. The list is restricted instead to those socio-cultural elements that are least frequently analysed by projects: the relationship with local knowledge, language issues and means of communication.[78]

75. Dimensions: analytical categories created by the human beings that constitute them. These dimensions are transmitted by symbols and consist of idea and acquired belief systems.
76. *Guide de planification de projets de santé* [Guide to health project planning], MdM, Paris, to be published in 2012.
77. These groups of factors are closely linked to each other: a context can be compared to a system in which the constituents give rise to relationships of dependency and reciprocity.
78. In the following pages there are several questions from Michel Sauquet's grid for identifying socio-cultural variables that may explain the Other's attitudes and operating modes (available on MdM website).

The relationship with local knowledge

→ What are the different sources of knowledge (scientific, popular, traditional, empirical, etc.)?
→ How much importance is given to experience?
→ What is the relationship between knowledge and authority? Who derives their authority from their knowledge and what knowledge exactly?
→ How are tradition and modernity defined?
→ What are the conflicts stemming from "tradition" and "modernity"?[79] Is there always a conflict between them?
→ To what extent do young people accept the older generation's values?
→ What are the different forms of knowledge regarding health? The different types of medicines? What are the associations that occur/could occur between these?
→ Who are the representatives of this medical knowledge?
→ What teaching methods are used? Who is allowed to teach? Who is allowed to go to school?
→ Does the relationship with knowledge depend on gender?
→ Etc.

Language

→ How many languages are spoken in the community?
→ Which languages are used and when are they used (administrative languages, languages used at school, etc.)?
→ How proficient are the different categories of people in these languages?
→ Which words in the main language's health vocabulary can and cannot be translated?
→ What is the role of writing? Is it a discriminating factor for a section of the community?
→ What is the purpose and how often is the spoken/written word used?
→ Etc.

Means of communication

→ How much freedom of speech is there?
→ What is the situation of the media?
→ Which channels of communication are used the most? The most traditional? The oldest? The most recent?
→ How do people communicate with each other (orally, in writing, letters, e-mail, mobile telephone, social networks, etc.)?
→ What are the information strategies? What are the provisions for capitalisation and exchange of information?
→ What is the country's level of communication with the rest of the world?[80] (Availability of Internet?)
→ How important are meetings and celebrations in communicating information?
→ Etc.

2 / The economic dimension of a community

DIFFERENT MEANS AND METHODS OF PRODUCTION AND ALLOCATION OF USEFUL AND LIMITED GOODS AND SERVICES. IDEAS AND BEHAVIOURS THAT GIVE VALUE TO MONEY AND MATERIAL ELEMENTS.

The economic dimension is an important aspect of a community's organisation. The richer a community, the more power it has, and therefore the greater its ability to fulfil its aspirations. [81]

The economic system in general

→ How precarious is the community?
→ What are the traditional social mechanisms for allocating wealth, (family obligations, gifts, potlatch, sharing within the community, trade, buying and selling with money, bartering, etc.)?
→ What are the notions and practices regarding the appropriation and/or sharing of resources?
→ What type of wealth can be granted by a mechanism such as marriage but not by another (money for example)?
→ How much money is available for community funds?
→ What resources are available for fundraising and how much (sponsorship, immigrants in the towns, loans from businesses)?
→ Is credit available? Are there credit unions? Investment companies? Tontine systems? What proportion of the population has access to them?
→ What is the relationship between the economic and social situation and health in the community? What level of health spending is authorised?
→ Etc.

The group's relationship with money, wealth and poverty

→ What does it mean to be "poor" or "rich" in the perception of other members of the group?
→ How big is the gap between earnings and the cost of living?
→ What aid mechanisms are in place for the poorest members?
→ What is the connection between money and motivation?
→ What pay practices exist?
→ To which priorities will money be allocated? Who decides?
→ How is money kept?
→ Are donations compulsory? What is the donation's value?
→ What is the significance of volunteering?
→ Etc.

3 / The political dimension of a community

DIFFERENT MEANS AND FORMS OF DISTRIBUTING AUTHORITY, INFLUENCE AND DECISION-MAKING.

The political dimension of a community is how individuals take decisions for the group. We are therefore not talking about ideology, which would come under the values dimension (shared ideas regarding right and wrong).

This is yet again an important dimension: the more political power and influence a community has, the greater the freedom it has to do what it wants.

The power structure within a community must be identified before undertaking any community action. It can also evolve as a result of an NGO action or the implementation of a project in a community. To what extent does our involvement give power to individuals

79. 80. **Michel Sauquet,** Identification grid of socio-cultural drivers governing the Other's attitudes and operating modes.

81. Here again, we are not examining the usual information: local currency, GDP, main economic activities and sources of income, availability of and access to resources, etc.

in the community who previously had very little or none at all (through training, for example)? What changes in the power structure occur within the community subsequent to our involvement?

Before launching a project, questions must be asked about the links to existing powers (visible or otherwise).

The community's political system in general

- → What mechanisms exist to allocate authority and influence within the community? Traditional (inheritance, chiefdom, family), modern democracy (vote, representative democracy), political decisions (trade unions, associations, organisations), charisma?
- → Is there a chiefdom system?
- → Is it traditional or co-opted by national governance or a combination of the two?
- → How much influence do those who are not formally recognised as leaders have: religious leaders, education officials, senior officials, dignitaries, doctors, elders, the rich, etc.?
- → To what extent does the traditional political system still exist?
- → Which political values are shared or not shared?
- → What are the major differences in the political values?
- → What are the important external factors? National political parties, members of the community in other countries, etc.?
- → Does the community's political system allow everyone to express their opinions?
- → Etc.

Political organisation and pertinent community levels

- → Who must be taken into account first?
- → On the basis of what criteria and which ethical grounds?
- → Who are the community's recognised leaders?
- → What is the relationship between them?
- → What role do the leaders and elected members play in the community's organisation?
- → Are any actors already established as formal associations?
- → Are there any networks? What are they?
- → Are there any institutional actors?
- → Traditionally, are individuals consulted by their authorities to make collective decisions?
- → To what extent does involvement in a project confer political power to a person?
- → What are the possible shifts in authority once a programme has been set up?

The relationship with power, authority and norms

- → What are the sources of legitimacy and authority (legal system, common law, religious law, historical legitimacy, etc.)?
- → How is legitimacy represented?
- → To what degree is authority accepted? Is it often challenged? Are there any forms of checks and balances?
- → Are the hierarchies clearly visible?
- → To whom are people accountable?
- → What are the rights and obligations of an individual regarding the community? What are individual and group responsibilities?
- → Etc.

4/ The social and institutional dimension of a community

FORMS OF INTERACTION BETWEEN INDIVIDUALS, ROLES AND STATUSES WITHIN A COMMUNITY.

This dimension includes institutions such as marriage, the role of the mother or the mayor, status, class, etc. For example, being leader is both a role and an institution. It also concerns interrelationships, expectations, judgements, responses and reactions. Transcending the whole community, it is the most complicated dimension to understand. A change in the social dimension will impact all five other dimensions.

The social organisation of a community is the sum total of all these interrelationships. In "simple" organisations, the family is the community and the society, as it defines every role and status. In complex societies, however, the family loses its importance in the midst of so many other forms of relationship.

The complexity of the organisation, the extent of the division of labour, the distribution of roles and of functions are therefore important aspects of the community or its ability to organise itself: the more organised and effective it is, the greater its ability to achieve its community and organisational goals.

Project promoters must be mindful of local institutions, the different roles they play and the different forms of social interaction.

Furthermore, it is important to have information on the relationship of the community with external projects, in other words, a community's past experience of projects. Work with communities differs according to their previous experience of projects and especially the damaging effects that these can have, particularly for "descendant" projects. Populations used to projects with little participation may not feel concerned, may be quite passive or allow some of the actors to steer a project towards more personal interests. Projects may have left people disappointed, perhaps because they did not deliver expected benefits or, yet worse, they may even have had a negative impact. The memory of such past experiences must therefore be taken into account and included in the diagnosis.

The community's social and general interaction system

- → What types of collective structures are there in the community (clans, ethnicities, families, organisations, etc.)?
- → What is the structure of the family/ kinship group?
- → What kinds of families? (Nuclear, extended, patriarchal, matriarchal, monogamous, polygamous)?
- → What type of strategy is in place for belonging to one or several communities, according to what is at stake?
- → What type of interaction model does the community have, (gender, inter-ethnic relationships, etc.)?
- → What system of social control is there in the community, (censorship, clearly displayed norms, gossip, etc.)?
- → What value is given to social relationships and what is the challenge? (question of survival?)
- → What makes up the community's social structure (organisations, clubs, political parties, NGOs, etc.)?
- → What are the traditional forms of solidarity?
- → What are the scope and nature of civic engagement?
- → How is the " common good" defined and managed?
- → What are the main events that have marked the life of the community?

What has their impact been?
- What are the latent or avowed conflicts? What are the strategies for avoiding or resolving conflict?
- What are the possible sanctions?
- What is an act of violence in the Other's culture?
- Where and how do people socialise?
- Etc.

Past "project" experience and the other organisations already present

- What is the community's previous experience of working with humanitarian projects?
- What are the activities of the other organisations present?
- Has the support/participation of the populations been sought?
- Do the organisations ask the population to participate? Which methodologies do they use?
- Did the projects take into account the population's requests?
- Was this an order from an institution?
- What was behind the action (an incident, response to a request, etc.)?
- How are the actions perceived and are they accepted?
- Who were the preferred agents and organisations?
- What expectations were created?
- What are the adverse effects resulting from this past experience?
- What does participation mean to the community?
- To what extent has the population been able to take over the project?
- What were the resources and skills of the individuals and groups involved?
- What local initiatives were put in place or at least attempted?
- What material, economic, educational or other means were deployed?
- How were these means determined?
- How is it possible for the populations to get involved in a project or become involved in the event of a crisis (natural disaster, epidemic, conflict, etc.)?
- How are the terms "change", "development", "social progress", "participation" and "project", etc., translated?
- What is the connection with interference? What is the perception of volunteering?
- How is international aid and the presence of the NGOs perceived?
- What are the resources and capabilities, particularly in terms of resilience, of populations affected by the disaster?
- How can availability be ensured over a certain period?
- Why are people prepared to devote their free time to participating in a project?
- What is the minimum and maximum amount of time they are prepared to spend?
- What perception do the populations have of my organisation and the people who work for it?
- Etc.

Risks

- What risks do people in the community take if they wish to participate in the project?
- What is considered a risk in the community?
- What risks is it permissible to take?
- How can these risks be reduced?
- How can I make sure that the people I am going to work with feel safe?
- Etc.

Minorities

- Which groups are marginalised within the community?
- What are the cultural foundations of discrimination?
- Which practices are considered discriminatory? What stigmas are there in the community?
- How can such people be included without increasing stigma?
- What adaption or integration strategies exist?
- Which tools and actions are used to combat inequality (positive discrimination, quotas)?
- Etc.

The relationship with the group ("I" and "we")

- Who can be worked with to build up the group?
- Who can be worked with on cultural decoding?
- Who are the mediators within the community?
- What can be said and what cannot be said in the community (because of taboos, a sense of modesty)?
- Etc.

5/ The values and aesthetics dimension of a community

THIS IS THE STRUCTURE OF IDEAS, THE NORM: RIGHT, WRONG, BEAUTIFUL, UGLY, TRUE, FALSE AND THE JUSTIFICATIONS USED TO EXPLAIN THEM.

This is the basis of judgements, judgements that depend on what is learnt during childhood. As a community expands and becomes more complex, heterogeneous and more connected to the outside world, values tend to change. Changing values are more often the result of change in the technological dimension or in the social organisation than the consequence of direct changes obtained from IEC messages.

The community's general value and ideological system

- What is the relationship between the individual and the norms (respect, deviance, etc.)?
- What are the community's shared values (right, wrong, good, bad, etc.)?
- Do values differ greatly from one person to the next?
- What are the gender relationships?
- What are the relationships with the elders?
- How are decisions taken (individually, collectively)?
- What is a risk? What is an emergency? What is an act of violence?
- What motivates people in their work?
- What in life is considered a priority? And in the budget?
- Etc.

The relationship to space

- Is space seen as an individual or a common asset? What are the differences between private and public space?
- What is the region's main type of spatial organisation (rural, urban, densely or sparsely populated)?
- How is housing spatially organised (function of the courtyard, communal living quarters, shared houses)?
- What social functions are given to the space? Is there a space for participation and community work, a space for dialogue (village square, health centre, church, school, palaver tree, etc.)?
- Does the Other have rules for the layout, construction and the distribution of spaces (places set aside for men or for women only, etc.)?
- In terms of distance, what is seen as nearby? Far away?
- Is physical distance an obstacle? Is it a necessity?
- How much does the community

move around (sedentary, nomadic, according to the seasons, etc.?
- → What is the relationship with migration (seasonal, gender-based immigration, men-only migration, possibility for women to move around, migration as a rite of passage into adulthood)?
- → Etc.

The relationship to time and the management of timeframes

- → What are the representations of time and how much importance is attached to time? What is the relationship with the notion of progression? Linear or cyclical time?
- → What constraints do communities have on their time (timetables according to different social categories: men, women, young people, etc.)?
- → What possibilities do they have for adapting their time?
- → What other commitments do the populations have that require their time?
- → What are the changes or causes of change to their timetables? (Irregular schedules)
- → Etc.

6 / The conceptual dimension and beliefs of a community

VISIONS OF THE WORLD, BELIEFS, STRUCTURE OF IDEAS ON NATURE, THE WORLD, THE ROLE OF PEOPLE, CAUSE AND EFFECT, ETC.

This dimension is often associated with religion, which is in fact only one part of the dimension as it also includes atheistic beliefs (for example, man created God in his image). These are shared beliefs (by all or part of a community when it is heterogeneous) on the origins of the universe, reality (Cartesianism, for example), etc.

The conceptual system / the community's beliefs

- → How do the members of the community regard the world?
- → What are their beliefs?
- → What were the founding events of the community?
- → How important is the recourse to supernatural, extra-organic, or non-material explanations during unusual events?
- → Which of the "universal" or world religions are represented in the community?
- → Which religious values are shared?
- → What is the status of religion in the community (secularity, State religion)?
- → What proportion of the community regards itself as a member of an official religious organisation?
- → What is the relationship regarding the divine and the sacred in everyday life?
- → How important and how frequent are religious festivals in the community?
- → Is the public/professional domain separate from the religious domain?
- → What is the rate of syncretism (addition of new beliefs without taking away from the old ones, contradictions) in the community?
- → What are life's milestones (rites of passage, initiations, etc.)?
- → To what extent does organised religion determine the community's values?
- → To what degree are these views shared or, on the contrary, are the source of disagreements?
- → How do people explain the causes of illness and misfortune?
- → Etc.

Dimensions interconnections

Any one project will usually impact all six dimensions of a community's culture. Bringing about change in one dimension will have repercussions on all of the others. For example, introducing a new way to fight malnutrition will require bringing in new institutions to distribute food rations. Learning any new way of doing things will require the learning of both new values and new perceptions.

There is a greater risk of adverse effects if the interconnections of change are not taken into account. Efforts must therefore be made to understand the consequences of change in one dimension have on the other dimensions.

It should also be remembered that it is difficult when developing a project to step back from one's own culture and keep in mind that the Other's culture may differ in some areas. This is simply because we are not always aware of our own cultural attachments and the cultural origins of our workplace reactions. The proverb: "it is a rare fish that knows about the existence of water" illustrates this well.

The experience, within your organisation, of working with communities

- → How do my organisation's policies and strategies enable community actions to be developed? How is participation viewed in the organisation's culture?
- → What are our usual ways of working with communities?
- → How do local and international actors portray participative approaches?
- → How do the donors' policies and procedures influence the work being done with the communities and how can they be handled?
- → How can the project be organised to evolve in such a way as to gradually integrate new people?
- → How can the communities be integrated into forward planning?
- → How can we facilitate dialogue and establish communication between the team and the volunteer community workers?
- → Who are the suitable intermediaries for communication with the teams?
- → What perception do the populations have of my organisation and the people who work for it?
- → What are the presuppositions or stereotypes of aid workers regarding the target community?
- → Who should be worked with to build cultural bridges between the organisation and the community?
- → Etc.

2 / QUALITATIVE RESEARCH METHODOLOGY APPLIED TO STAKEHOLDERS' ANALYSES

Part of a dynamic process, the qualitative investigation should help answer the questions that we ask ourselves during the diagnosis phase and all through the project. Understanding socio-cultural aspects that are often overlooked in classic diagnoses should in fact be the focus of specific research.

The overall aim of the investigation, as a result of a contextualised analysis, is to broaden knowledge of the definition of

levels relevant to the community, its organisation and its traditional forms of solidarity and the implications of past or future projects.

The four stages of the qualitative investigation

1/ Defining the topic for research and its associated issue

Taking into account the issues that arise from the field investigation and depending on the topic it is address, the study can:

- → identify the socio-cultural factors that determine the organisation of a community, the relationships between the individuals that belong to it, the perceptions and representations of problems and needs, the exercise of authority, the respect for social norms, etc.
- → assess the solidarity systems (traditional or recent) that already exist within the community but also at the level of the recognised actors who serve as a contact point when there are problems or decisions to be taken within the community.

2/ Preparing the investigation

This requires preparing documentation, information (local press, radio, reports) and creating fact sheets.
The first task is to compile a bibliography. There may already be studies that will help in tackling the relevant issues from the outset. It may be useful to create different fact sheets to classify the data by topic (religion, economic elements, family structure, etc.)

3/ Setting up an investigation methodology

The main qualitative data collection methods that should be used in order to analyse individual and group representations and behaviours regarding the notions of community and implication/participation, are interviews, observations and focus groups.

Methodologies from the various social sciences should therefore be used in order to:

a/ establish a detailed description of the different key actors: leaders, religious leaders, community workers, healers and matrones, health workers from different structures, number, role, motivation;
b/ analyse the population's attitude towards these different actors;
c/ specify the levels of existing solidarity and understand what differentiates the family from the community. Who helps whom?
d/ understand what are the responsibilities of the individual and the community, particularly in decision-making;
e/ if community workers are present, understand their role, legitimacy and to what extent they are recognised. Analyse where applicable the real function of committees in national politics.

The investigation should combine the three qualitative data collection methods, namely interviews, focus groups and observations. The issue of sampling in this type of qualitative research is not a question of statistical representativity. Selection of participants depends on their relevance to the investigation's objectives.

The analysis of the portrayal and observation of daily life should create an understanding "from the inside" of representations, attitudes, dynamics and practices of the population and the underlying rationales as well as the logic of the different actors' actions. To achieve this, the views and observations need to be reconstructed in the widest possible social and historic context.

4/ Conducting the investigation

First and foremost, it is important to prepare field visits, to inform the population in advance and to try and organise a meeting with the community's leaders or elders. Thought must also be given to who is the first person to be contacted and to the intermediaries and interpreters. A bad choice at this stage could negatively impact what follows and restrict access to certain groups. As much effort as possible must be made to respect rules and social norms as well as the recognised social hierarchy. In many societies, the first meeting with a community must be made through its elders and leaders.

During this first meeting, introductions must be made in clear and precise terms including reasons for being and the objectives. And, in many cases, a large formal assembly at which the whole community is present must be organised. This is not the best time for collecting interesting information (these sessions are determined by relationships of power where without doubt the most excluded will not speak) but it is a crucial step demanded by etiquette.

Several interviews and focus groups should not be conducted on the same day as they are tiring and require a great deal of concentration to keep up with the discussions, find the right follow-up questions and indeed ask the right questions in the first place. In general, a very long interview is exhausting.

It is important to take comprehensive field notes during spontaneous conversations between individuals, between workers and beneficiaries (their questions, remarks and comments and so on) and between beneficiaries and their families, etc. These notes can be used to double-check and verify some of the data collected during more formal interviews. Reformulation of the questions is then possible, allowing more in-depth questioning on certain points during subsequent interviews. Other methods for collecting specialised data (life stories, bibliographies, content analyses, case studies) can also be used. The aim in using these is not to take an interest in exceptional characters or to conduct psychoanalytical interviews. Nor should a case study of an individual be seen as a representative study: individuals are not interchangeable and a qualitative investigation differs from a statistical one. An individual in a community is the product of a social history, i.e., the product of the many interactions that he or she has experienced. In this way, a personal story can be read as the meeting point of several group stories.
N.B.: these interviews should be scheduled for an appropriate time (not during prayers, for example).

Examples of question guides on the representations, values and strategies of the project stakeholders

1/ Interview guides

Interviews should be semi-directive in this type of study. Detailed information can be collected on the social norms and sanctions applied in the local society, pressure exerted by the entourage, conflicts and the possible margins for manoeuvre and adaptation of the target populations.
Questions are formulated and organised in advance to collect the same type of information from the different actors.

EXAMPLES OF INTERVIEW GUIDES ON THE NOTION OF "COMMUNITY" AND "COMMUNITY SPIRIT"

INTERVIEW WITH A VILLAGE LEADER ON HIS COMMUNITY

Aim of the guide: understand the leader's role, influence and main difficulties, etc.

Date:	Gender:	Place:
Time:	Age:	

	Question	Keywords and vocabulary	Follow-up questions
Q.1.	Can you describe your everyday role to us?		Can you describe a typical day?
Q.2.	Who selected you and how?		
Q.3.	Who comes to see you and why?		What do you do? What help do you provide?
Q.4.	What is your relationship with the other leaders? (Other village leaders, religious leaders, elders, dignitaries, etc.)		
Q.5.	Can you tell me about a time when people in your community helped each other out?		
Q.6.	We sometimes hear people talk about "community spirit"; what does this mean to you?		

ISSUE: What are the main difficulties that could upset the natural balance within a community (disagreements, individuality, power play, hierarchy, lack of authority)?

Date :	Gender :	Place :
Time :	Age :	

	Question	Keywords and vocabulary	Follow-up questions
Q.1.	In your opinion, what do the members of your community share or have in common (practices, values, knowledge, etc.)?		How and where do people share things? (Try to list or detail as many as possible.)
Q.2.	Starting with the most important and ending with the least important, can you classify what you share with your community?		Ask for an explanation of the classification
Q.3.	In any community, there are sometimes tricky situations between people. In your opinion, what can lead to issues between people in the community?		Try to get a list or details for as many as possible.
Q.4.	Drawing on your own experience, tell me about a tricky situation in your community. What were the reasons for these difficulties?		Try to get a list or details for as many as possible.
Q.5.	How can an individual (with his or her own beliefs and values) represent a difficulty within the community? Or: What should be done when an individual's position comes into conflict with the group?		Try to get a list or details for as many as possible.

EXAMPLE OF A FOCUS GROUP GUIDE

ISSUE: what are the relevant levels of community participation?

General information	Date	Time(start, finish)	Place

Participants	Initials (if confidentiality is required)	Gender	Age	Profession

Q.1.	What do you call a “community”, “a family” and “a group”?	
Answers		
Attitudes and level of participation	Keywords, vocabulary	Moderator’s follow-up question : What differentiates the family, the group and the community?
Q.2.	What experiences are shared in the family? In the community?	
Answers		
Attitudes and level of participation	Keywords, vocabulary	Moderator’s follow-up question
Q.3.	In the event of a health issue or emergency, who in the group decides what should be done? Whose opinion is sought? Why? On what basis?	
Answers		
...	...	...
Q.4.	How does the community rally round to help an individual or family?	
Answers		
...	...	...
Q.5.	What is the extent of community’s responsibilities? Of the family? Of the individual?	
Answers		
...	...	...
Q.6.	What are the main difficulties faced by the members of your community? Who are the most vulnerable?	
Answers		
...	...	...

ISSUE: How are decisions taken in your community?

General information	Date	Time (start, finish)	Place

Participants	Initials (if confidentiality is required)	Gender	Age	Profession

Q.1.	How is a person who has influence over a group and decision-making recognised? What are the determinants of authority or legitimacy?	
Answers		
Attitudes and level of participation	Keywords, vocabulary	Moderator’s follow-up question: Who are the leaders and how are they recognised?
Q.2.	What role do the leaders play in managing the daily life of the community?	
Answers		
Attitudes and level of participation	Keywords, vocabulary	Moderator’s follow-up question:
Q.3.	What important strategic choices and decisions have to be made regarding the community? How are these decisions presented to the community?	
Answers		
...	...	...
Q.4.	How are these strategic decisions taken? What are the possible obstacles to decision-making?	
Answers		
...	...	...
Q.5.	What strategies do individuals use to make sure that their opinion is better taken into consideration? On a daily basis, how do you make sure your opinion is valued in the case of disagreement?	
Answers		
...	...	...
Q.6.	What are the reasons behind your acceptance of a decision or choice made for the whole group?	
Answers		
...	...	...

2/ Focus group guides

Focus groups serve to encourage participants to interact with each other on given topics. This method is not very well adapted to studying topics relating to an individual's private life and can be awkward with regards to, for example, power struggles, compromises and conflicts. Sometimes the information required can only be obtained through in-depth interviews and observations of practices and real-life attitudes. However, the method is appropriate for understanding what is said and what is not said in a group and also how things are expressed within a group. Furthermore, these group discussions reveal opinions and provide observation data on behaviours and interactions between participants during the discussion (laughter, smiles, embarrassment, etc.).

The criteria for selecting participants depend on the topic (either the family, i.e., the father, mother-in-law, aunt, or other women from the neighbourhood, students, etc.). Groups should be as far as possible homogenous in relation to their socio-cultural origins and their socio-economic level.
Attention must be paid to the composition of the focus groups so that minorities feel able to express themselves freely.[82]
Similarly, it must be remembered that it is more difficult for people who do not normally have the right to speak in public to do so in a group situation. The choice of language is also important, i.e., consider translating into the minority languages and avoid using complicated vocabulary that cannot be translated.

3/Observation grid

The observation method should be directed at certain behaviours, practices and the stories that go with them. It should allow for an exhaustive record to be made of the sequences or technical gestures (ceremonies, general assemblies, the different stages of the delivery of a baby, preparing a meal, breastfeeding, cleaning, etc.). It allows for the collection of spontaneous reactions and views that are not necessarily expressed during interviews. It also allows for the evaluation of the importance of socio-economic, environmental and cultural factors.

For each topic, an observation guide should be drawn up beforehand and go hand in hand with a setting of the context (place, date, participants), an indication of the length of the observation and the social position (status, gender, age) of those being observed.

The observation should make it possible to appraise the disparity between what the participants say and what they actually do. If an interview shows how the participants perceive a practice, observation can then be used to try and determine the practical details surrounding the practice. Used in retrospect, it can also enrich an analysis and the interpretation of any views held.

The issue of partnerships

Partnership is defined by MdM as "an established relationship between partners, in other words, associates, two individuals, groups or structures that come together in a common idea or fact (organising an action, carrying out a project, etc.). Partners, allies, associates, colleagues: this relationship can take different forms according to the shared goals of the different actors".[83]

EXAMPLE OF AN OBSERVATION GRID
FOR A GROUP OF REFUGEES/ASYLUM SEEKERS
SPECIFIC ISSUE: the existence – or otherwise – of leader(s)

Question	Time and date	Place	Observations
1. Are there individuals in the group who stand out during interaction with external members? How? (They translate for the others because they understand the language)?			
2. When and for what reasons are there group discussions? How do people take the floor and speak?			
3. Who are the people who stand out in shared activities (supervision, resources research, refurbishment, etc.)?			
4. Those who stand out do so on the basis of what legitimacy? Is the emergence of leadership facilitated by age, gender, experience?			

The socio-cultural diagnosis phase should facilitate the meeting of various partners: aid and development workers, residents, beneficiaries, health system users.

A "good" partner can be identified through an analysis of the different stakeholders.[84]
The stakeholders are all people or organisations likely to have a connection with the projects, be able to influence them or be impacted by them, either directly or indirectly, positively or negatively. They are the second element of the context (after the factors influencing a situation) that should be analysed during the context analysis in the diagnosis phase.

Potential partners normally emerge spontaneously during this context and needs diagnosis phase. During the analysis of the partners' reactions several factors should be taken into account, such as their impartiality or neutrality, legitimacy, technical competencies, etc. Of course, it is difficult to find local organisations that perfectly fulfil all the criteria that may be determined. So, drawing up a list of the priority or non-negotiable criteria for your organisation is necessary. Sometimes there is no existing or recognised structure. In this case, a "partnership" can be used to support the creation of new committees. However, attention must be paid so as not to impose committees that would be alien to the prevailing work or solidarity culture. Moreover, these new types of organisation should not superimpose or overload other forms of aid or solidarity, at the risk of weakening that which already exists.

82. Guide "Collecte de données, méthodes qualitatives" [Data collection, quantative methods], MdM, 2009, 2nd edition 2012.
83. Forum 30 ans de partenariat : " Humanitaires et partenaires : nouvelles donnes ? " [30 years of partnership forum: "Humanitarian aid workers and partners: a new reality?"] Revue humanitaire, 2010.
84. For the analysis of stakeholders refer to the **" Guide de planification de projets de santé "** [Guide to health project planning], MdM, Paris, to be published in 2012.

"Mushroom" organisations also need to be sought out (NGOs which spring up like mushrooms after rain), as they are often already on hand to harness the resources that pour in after a disaster.

To encourage appropriation, local cultural references and traditional mechanisms for consultation that the populations will be able to identify with must be used.

Establishing partners/networks requires an in-depth analysis of the context. **The following must be accomplished to identify reliable partners[85]:**

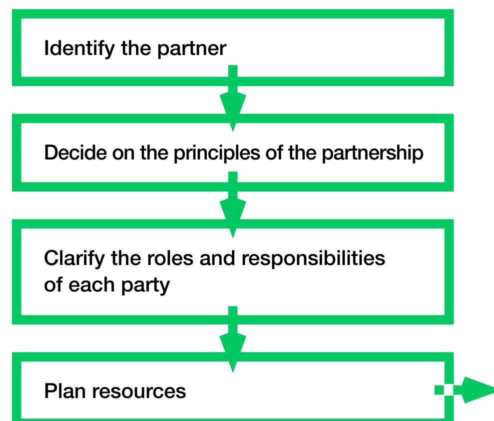
- → Draw up a list of all those participating in the action;
- → Identify the institutions, groups, organisations, individuals, etc.;
- → Establish the different domains (social, economic, political, etc.);
- → Define the different types of partners: residents, institutions, politicians;
- → Locate the strengths (interest and influence) of the different stakeholders[86];
- → Identify the different degrees of involvement.

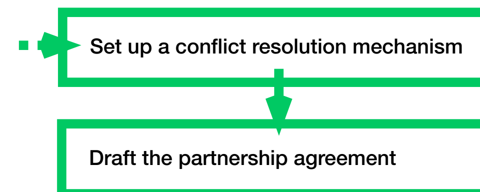
While a partnership can be established at various stages in the project, this is better done at the start to ensure that all those concerned understand the roles and goals. Similarly, the roles and responsibilities of the different parties must of course be clarified right from the beginning so as to avoid misunderstandings, disagreements and frustration. Which resources does each partner need to call on? Who participates in decision-making? Who does what? Here, roles need to be allocated realistically which calls for sound knowledge of the different partners' capabilities. A steering committee is also a useful tool but agreement must be reached as to who represents each partner, his or her ability to make decisions and the frequency of meetings.

Coordination Sud's[87] European platform has identified a set of nine criteria for establishing robust, balanced and long-term partnerships:

- → convergence on the purposes of the project;
- → joint development of an implementation strategy;
- → extent and method of involvement of each partner in the project;
- → agreement on the distribution of roles, activities and means;
- → complementarity of skills and means;
- → reciprocity;
- → long-term commitment;
- → quality of relationships between people;
- → transparency.

Groupe URD has designed the following diagram to describe the steps for establishing partnerships:





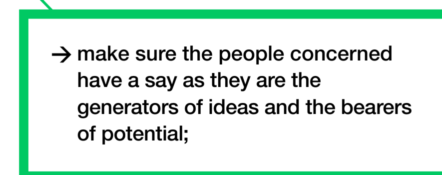
3 / THE IMPORTANCE OF A FORMAL WRAP-UP OF THE DIAGNOSIS

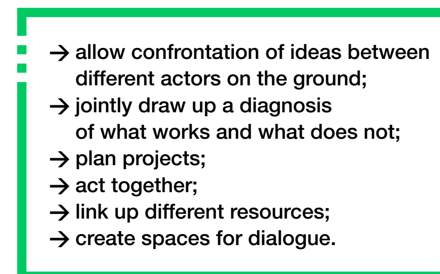
In the same way that introductions are important when beginning the diagnosis, so too is a formal wrapping up, particularly if participation in focus groups, interviews with leaders, observations in the villages, etc., have created expectations that can be generated by the very presence of an organisation and researchers.
Therefore, a presentation of the conclusions of the diagnosis conducted collectively and an explanation of the next steps must be made.

The transition from diagnosis to action occurs through:

- → feedback on information to the different local actors;
- → joint analysis of information;
- → debate on proposed actions;
- → identification of priority problems and goals.

IMPORTANT PRINCIPLES





The diagnosis process must be renewed; the information collected must be updated and supplemented.

4 / PROJECT PROGRAMMING AND IMPLEMENTATION

The customary stages of project planning,[88] determining objectives, designing activities, decision-making regarding human and material resources, preparations for implementation and set-up, follow-up and evaluation of an action will not be examined in detail here. However, it should be remembered that for projects using a community approach, the community's assets and resources must be taken into account, as should its limitations, constraints and its ability to seize opportunities.

Current knowledge, ideas and experience must be properly considered and choices made must be of value to the populations. It is, after all, somewhat difficult to launch an action if all the different parties involved do not have the same understanding of the problem!

85. URD, *Manuel de la participation* [Participation Manuel], *op cit.*
86. See the analysis table of stakeholders in the **" Guide de planification de projets de santé "** [Guide to health project planning], MdM, Paris, to be published in 2012.
87. Commissioned by Concord's working group on Funding Development and Relief to examine in closer detail the issue of quality partnerships.

88. MdM, "Guide de planification de projets de santé" [Guide to health project planning], Paris, to be published in 2012.

N.B.: during the analysis and when identifying solutions, particular attention must be paid to how objectives are prioritised and who the target populations are to be. Projects generate power struggles and a multitude of interests. Decisions can cause numerous grievances and favour some individuals while excluding others. Social tensions should not be increased and care must be paid to any potential risk of manipulation at the hands of specific groups. And, making a marginalised group the target of an action can lead to an even stronger stigma being attached to its members. The planning process is also a repetitive business and calls for flexibility.

For the project programming phase, which means transforming the problems identified during the diagnosis into objectives for the potential project, refer to the "Health Project Planning Guide" and more specifically, to the exercises on problem and solution trees.

Prioritisation

Prioritising solutions is crucial: choosing an inappropriate solution can lead to a whole host of difficulties during later stages. Many humanitarian projects fail because of imported solutions decided from the outside, rather than from a careful analysis of the populations' needs.

A valuable exercise is to determine those solutions the populations are familiar with, which ones are already being used by other organisations, the solutions that the organisation itself already uses and lastly, the solutions based on a combination of traditional and modern expertise. The keyword in this quest for solutions is negotiation!

Discussing the different priorities with populations is time-consuming. Efforts must be made to ensure that they understand and share the choices and priorities that have been decided. This means they must be communicated to the populations before approving them.

In any event, there must be a complementarity with local knowledge, practices and techniques. Not taking these into account can lead to a loss of quality in activities, poor sustainability and, unable to identify with them, loss of interest on behalf of the populations.

Targeting: a sensitive issue

Not homogeneous, population groups have different priorities. Part of determining a project's objectives supposes selecting a target group. Targeting is sensitive and must be handled carefully. It is often not understood or simply not socially acceptable, particularly in societies with a survival economy and an unspoken social contract of those receiving sharing with those who have nothing. It has often been observed during projects that target populations receive supplies but then go on to redistribute them to those not targeted.
Targeting must also be participative, if it is to be understood and embraced. This means that the population should participate in defining the criteria and information given regarding the targeting process.

However, identifying criteria is a complex and sensitive process as here again there is a clash between the different perceptions of "vulnerability" and "beneficiary". Unfortunately, targeting is also a process that cultivates discrimination and stigmatisation, particularly for those targets based on physical criteria. This is the case of nutrition projects for children, which lead to a whole category of mothers being singled out as "bad" because their children are targeted by the project as being "malnourished".
It is important during targeting not to isolate a specific group but rather to work with all the other categories that the group comes into contact with. Working with young mothers, for example, means working with their mothers and mothers-in-law, husbands, and so on.

The targeting process can have major repercussions on social relationships as it can exacerbate discrimination and the power plays. It needs to be transparent and the selection criteria made known to the community.

Activities

Let us not forget that it is very difficult to ask people to participate in a project if they have not been able to contribute to the planning process because they may lack motivation to participate in a project not developed by them. At this point, thought has to be given to the main aims and motivations for engaging with the population in a process of participative implementation and follow-up. Decisions have to be taken on who does what and how responsibilities are distributed amongst the different parties. Care must be taken to make sure that individuals are not overloaded and to check that the project will not affect their capabilities and other commitments to the community or their personal lives. Imposing alien forms of organisation runs the risk of poor appropriation and integration of actions.

Attention must also be paid to resource management for the project. Community workers can be subjected to huge pressure from those around them to use these resources for other purposes. So, consideration needs to be given to resource management responsibility and duties that could increase the exposure and insecurity of community actors.

Means of communication

Means of communication should be adapted to the cultural context; in other words, they should be accessible and appropriate. Attention must be paid to the language or languages chosen as well as to the way information is presented. There have been cases of IEC messages shocking populations because they did not comply with their particular standards of decency. For example, one such message featured naked women to raise awareness about giving birth.

And, controlling information and the way in which it is circulated is a source of power, so care must be taken to ensure proper access to it. Some people, such as undocumented migrants, young women under the control of their husbands, etc., can find it physically difficult to access such information, not to mention illiteracy or language issues.

Different methods of communication can be used: meetings, discussions, display boards, assemblies, door-to-door visits, etc. The populations should be consulted as to the most effective methods habitually used in their community to inform people.

Involving the population is crucial when designing materials to ensure that they are relevant in the local culture. Beneficiaries, workers and partners must all participate in drawing up and distributing messages. This involvement enables the project team to take into account ideas put forward by the workers who will be using the tools, shows them that the work they put into interpreting and adapting to their context is valued and erases the negative image of health education as an imposition of foreign standards. Fostering exchanges of information and negotiations on what can

be said and done needs to be instituted.
For example, IEC can be developed through case studies, real situations and encouraging populations to reflect on problems in order to get them to participate in finding solutions. Anonymity must always be respected when examples are used.

Once the tools have been designed, they must be tested to check:
- → their effectiveness;
- → correct comprehension: interpretation of pictures;
- → no important aspects in the representation of the context have been omitted.

It must be kept in mind that the interpretation of a picture resides on the codes unique to each culture and each social group. One single picture can have several representations and, not adapted to the target audience, may not only have a negative effect but may well be counter-productive. This is because pictures can be the vehicles of a meaning that they were not intended to convey and even cause a cognitive dissonance, in other words, rejection by those being targeted. And, culturally inappropriate images can be unacceptable.
Health education tools should be developed based on accurate knowledge of the representations, context and socio-cultural organisation of the target audience. Preliminary research can provide this knowledge but it takes time.

Pictures can be adapted in the course of a programme, thanks to the input of the workers who use them. Adapting materials according to the people they work with boosts message credibility. However, programmes must from the outset allow for the flexibility required to factor in such adjustments, particularly with regards to pictures.
Care must also be taken to ensure that the different means of communication are effective in the populations' cultures. In many countries theatre, for example, is not a traditional form of communication. Although it reaches out to a large section of the population who are attracted by its entertainment value, there is no guarantee that its message will in fact be retained. The style of this type of communication generally comes before the message itself for people not used to it.

The issue of follow-up and support

Providing follow-up and support to community workers can help maintain their motivation. Follow-up of local actors allows them to measure their results and gives them the opportunity to air their views on the running of the project. Their comments and recommendations should be taken into account for the remainder of the project.

Quality criteria should be determined in cooperation with the populations. Often highly subjective, a good understanding of what a quality project actually means to them is therefore required. And of course, agreement must be reached on the follow-up method and on who should participate. Here again, community members charged with carrying out the follow-up may be subjected to pressure or even put in danger if they pick up on mistakes or publicise mismanagement. It is important to differentiate between the areas that can be followed-up by community members and those that are more sensitive, such as budget follow-up, which should be handled from outside the community to avoid any unnecessary risks. Methods that respect anonymity are a possibility. For example, questionnaires can be collected from and placed discretely in public boxes. Some subjects are highly sensitive and cannot be discussed in a group, so individual interviews have to be set up and held in quiet places away from the gaze of others.

Lastly, feedback on the results should be given to people to maintain the populations' trust, motivation and respect. However, acting on this feedback presupposes the flexibility to be able to modify and adapt the project accordingly.

What support must be deployed to ensure the long-term commitment the community workers? This question requires an answer upstream.
People who become activity workers should receive training, follow-up and supervision. Training is always greatly appreciated and can take various forms, according to topics and requirements. In many community health projects, community workers benefit from initial and then six-monthly refresher training, for example.

Closing a programme is difficult in many projects. However, just as involvement and participation can facilitate appropriation at the beginning of a project, they can generate natural transfer mechanisms. For this to happen, preparations must be made early on, right from the participative diagnosis stage.

5 / EVALUATION

As above, this section does not provide in-depth detail of the steps to evaluate a project but focuses on the evaluation of community participation.

The aim here, therefore, is to give those involved in the projects and the populations in question the opportunity to give feedback on the relevance and the quality of participation in a project in order to shape its development and/or any future projects. The relevance of implementing a participative approach and how it complies with the community aspirations should be examined.

Evaluators must be chosen carefully and the evaluation must be objective and seen as such by the populations. The team may exclude certain groups from participating in the evaluation and there may be people reluctant to express their opinions in public. Restrictions may be placed on women's freedom of movement or their time so being aware of the ideal moment and place to hear what they also have to say is key.

In order to avoid misconceptions regarding the evaluation and its impact, it is important to provide the population with an explanation of its objectives beforehand. For example, care must be taken to ensure that everyone fully understands the term "evaluator", that it has the same meaning for everyone and does not have a misleading or negative connotation (spy, informant). Furthermore, the more people understand the benefits, the greater the participation in the evaluation and the more useful it will be.

Lastly, the most appropriate tools for a participative evaluation are interviews and focus groups. Nevertheless, care must be taken not to ask sensitive questions during focus groups but rather in individual interviews to ensure the safety of individuals and data confidentiality. These interviews and focus groups must be, of course, conducted in local languages. The choice of interpreter also counts, as he or she must be capable of grasping the subtleties and nuances of the languages and also at ease with the methodologies. It is often preferable for the interpreter to be external to the community so as to avoid any bias in perceptions. However, sometimes individuals can be reluctant to raise certain issues in front of a stranger. This should be addressed on a case-by-case basis.

Formal feedback on a large section of the results as well as a translation of a public document can be arranged. With this in

mind, this document should not be too technical or scientific but use a vocabulary easily accessible to all. This can also be an opportunity to thank the participants.

EVALUATION OF PARTICIPATION: QUESTIONING GRID

Who participated?
Who did not participate?

Draw up a list of key individuals who participated or who should have participated but were not involved

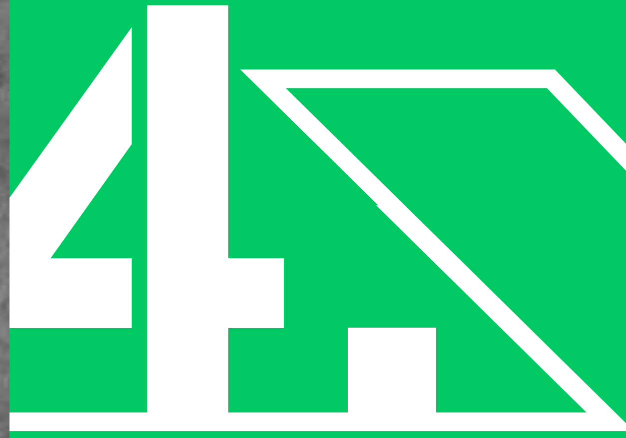
- → How did the project integrate the elements collected during the socio-cultural diagnosis?
- → Were existing structures, peoples' contributions and ideas taken into account in the development of the project and in decision-making?
- → How were the individuals involved?

List the techniques used: assemblies, focus groups, meetings with partners, etc.

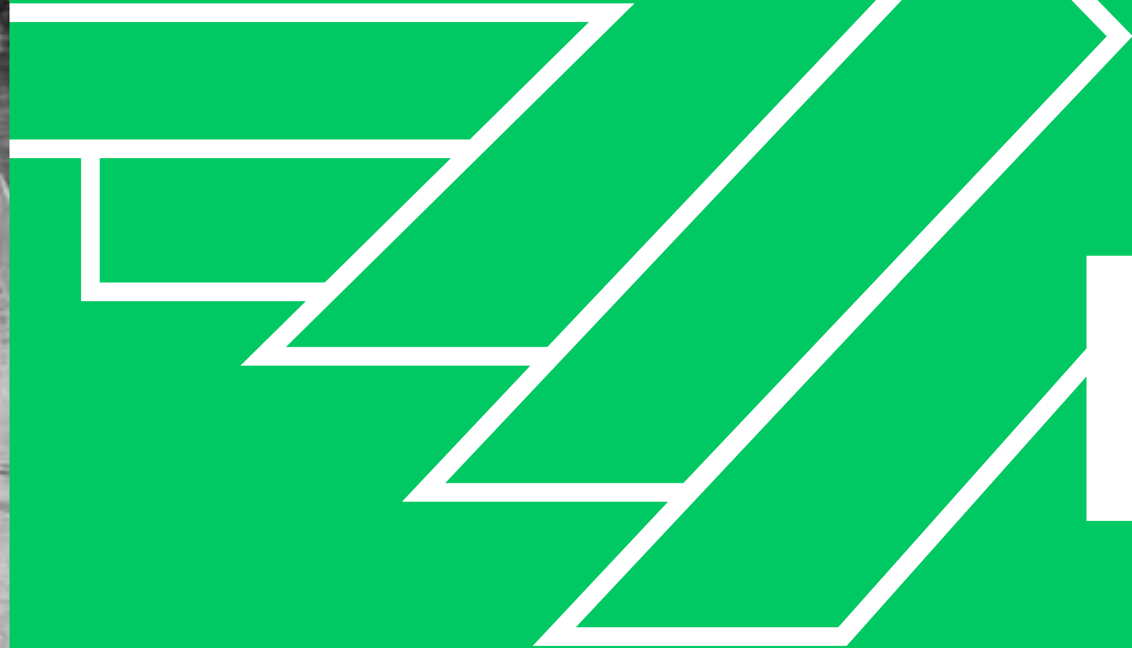
- → List the actions taken by the community actors: IEC, prevention, meetings, management, etc.
- → How effective was their participation?
- → Is the population satisfied with its level of involvement?
- → Were the people involved representative of the whole population?
- → Were any individuals or groups excluded from the community actions? Why?
- → Was it possible to conduct the community actions with the minorities without making them feel more stigmatised or threatening their security?
- → How were minority groups able to participate in the actions?
- → Was the community strategy implemented as planned? What were the discrepancies?
- → Did the populations' participation lead to their main concerns being taken into account?
- → How was the information transmitted? How effectively?
- → Are there any local strategies or capabilities that could be reinforced?
- → Did the project take into account lessons learnt from previous aid projects?
- → Etc.

6 / CAPITALISATION

Working with communities can also facilitate capitalisation efforts. Wrap-up meetings provide a forum to discuss with populations what has been done, perceptions of the project and ascertain what people will retain, either tangibly or intangibly. They can also be an opportunity to learn lessons from the experience of past projects. During these meetings, capitalisation documents can be drawn up to be given to the population in order to ensure the durability of the programme's actions.



4. CONCLUSION



CONCLUSION

These guidelines aim to clarify the concepts of community and participation. The result of discussions held during the “Working with Communities” workshop, they serve to show just how complicated these concepts are. They raise numerous questions and demand an in-depth analysis of the meaning of “community participation”.

Challenging apparently simple concepts has enabled us to show the diversity in the definitions of the words “community” and “participation” and their impact on building common actions.

We have been guided by a desire to improve the understanding of what is at stake in the community approach, and more particularly, in the relationship between a programme and a population, all the while taking into account the different socio-cultural levels in this relationship. As we have shown, the notion of time is an important factor in any community approach. It takes time to get to know and understand each other to build a common culture, both essential to a successful partnership. The success of any community approach depends on building fair and equal relationships between the different groups of people involved – aid and development actors, partners and beneficiary populations.

Emphasis has been placed, therefore, on the many issues that the question of participation raises in order to propose a methodology focusing on an understanding of the socio-cultural context. The aim is to foster open-mindedness and a critical mind-set to allow a programme of effective and appropriate actions to flourish. This methodology, based on elements for analysis and questioning grids on a project’s stakeholders’ representations, values and strategies, simultaneously draws on three types of anthropology. Firstly, political anthropology, through synthesising and analysing programmes already in place; secondly, health anthropology, through the analysis of procedures, structures and relationships between solidarity workers and the populations in health care interactions and lastly, cognitive anthropology through research examining experiences and the populations’ needs, as well as their perceptions of their health.

In identifying the obstacles and challenges associated with participation, these guidelines aim to promote the adaptation of future projects to the socio-cultural realities and perceived needs of the populations in question.

And lastly, they call for any community approach to be placed within an enriched ethical framework, in other words, a framework that gives a voice to those most affected. It also calls for support for actions based on the defence of patient’s rights and their empowerment – the core of the ethical values that guide Médecins du Monde projects.

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APPENDIXES OFFERED ON THE CD-ROM

- **Film on the experience exchange workshop held in Dhulikel, Nepal** in 2010.
- **Examples of interview guides appraising notions of "community" and "community-related"** (FR-EN-SP):
  Example of an interview guide / Example of focus group guides /
  Example of an observation grid
- **Research protocol and interview guides** – Madagascar, 2010 (FR)
- **Sauquet M., *33 questions to examine the "intercultural". Grid for identifying socio-cultural variables that may explain the Other's attitudes and operating modes,*** Dec. 2011.
- **Study: "Community Health Workers",** draft, MdM, 2009, (FR)
- **Study: "Traditional Birth Attendants",** draft, MdM, 2009, (FR)
- **Presentation of the internet site looking at socio-cultural determinants and access to healthcare** (FR-EN-SP)

OTHER BOOKS PUBLISHED
IN THE SAME COLLECTION

- ***"Data Collection - Qualitative Methods",*** MdM, May 2009, 2nd edition 2012. DVD included
- ***"Violence Against Women*** *- Gender, Cultures and Societies",* MdM, September 2009.
- ***"Gender-Based Violence Prevention & Response -*** *A Methodological Guide",* MdM, 2010.
- ***"Health Education*** *- A Practical Guide for Health Care Projects",* MdM, June 2010.
- ***"For Ethics in the field - Sensitive Personal Data Management",*** MdM, September 2010 (electronic version only).
- ***"Data collection - Quantitative Methods*** *- The KAP Survey Model (Knowledge, Attitude & Practices)",* MdM, May 2011. DVD included
- ***"Sociocultural Determinants of Access to Healthcare",*** MdM, May 2012. DVD included
- ***"Working with Communities",*** MdM, May 2012. DVD included

TO BE PUBLISHED
- ***"Health Project Planning",*** MdM, to be published in 2012.

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Quel est le sens du mot « communauté », qu’entend-on par « participation communautaire » ou « implication » ? **Quels sont les enjeux de ces concepts dans nos programmes humanitaires aujourd’hui, leurs atouts, leurs limites ?** Ce guide, issu d’un atelier d’échange d’expériences s’étant tenu en 2010 au Népal, vise à établir un ensemble de définitions essentielles et à mettre en évidence la pertinence opérationnelle de ces concepts. Mais devant ces problématiques mouvantes, il en appelle au questionnement systématique sur notre posture d’humanitaires face à la « part de l’autre » dans la question des soins.

What does the word “community” mean? What do we understand by “community participation” and “involvement”? **What are the challenges posed by these concepts in the context of our humanitarian aid operations? What are the strengths and what are the limitations?** Written after an international exchange workshop held in Nepal in 2010, this guide attempts to draw up a set of essential definitions and to highlight the operational relevance of these concepts. But these shifting issues call for a systematic examination of our position as humanitarians confronted with the “role and the participation of the Other” in the provision of health care.

¿Cuál es el sentido de la palabra “comunidad»? ¿Qué se entiende por “participación comunitaria” o “implicación”? **¿Cuáles son los desafíos que plantean estos conceptos en nuestros programas humanitarios en la actualidad? ¿Sus ventajas? ¿Sus limitaciones?** Esta guía, fruto de un taller de intercambio de experiencias celebrado en Nepal en el 2010, pretende establecer un conjunto de definiciones esenciales y poner de relieve la pertinencia operativa de estos conceptos. Pero ante estas problemáticas cambiantes, apela al cuestionamiento sistemático de nuestra postura como humanitarios en relación con “la parte del otro” en la cuestión de la atención sanitaria.

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