

# Involving Communities

Guidance document for approaching and cooperating with communities



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## About the guidance document

This guidance document is based on the joint work of the Vienna Evaluation Unit and MSF OCBA during the last few years. The common goal is to raise awareness of the importance of medical anthropology as an additional and alternative tool for better understanding perceptions of health and disease. Therefore, this guidance document aims at enhancing the work of the field teams when approaching and searching community involvement.

Involving communities in programme design and implementation is not a new concept; yet there is an increasing demand for clarity on how to do this. Given MSF's focus on emergencies, community involvement has not been a top priority in the organisation. However, in specific mid-term programmes more and more community-based approaches are applied.

Working closely with communities requires a thorough understanding of the cultural, social and behavioural background of the communities we are working with. A profound understanding of local, contextual, and cultural specificities will help to design programmes that respond appropriately to the needs of the beneficiaries. A relationship of mutual respect and understanding with the affected population is central to any community approach and intervention.

Working with communities can increase the relevance and impact of a humanitarian project. It helps to reduce or avoid negative consequences and ensure positive implications during and beyond the project duration.

In addition to medical support for patients, social support is considered a key element, which is mostly covered in cooperation with the communities patients are living in.

Social support activities include health promotion (HP) activities, home-based care (HBC) providers, community health worker (CHW), treatment supporters in HIV/AIDS and TB programmes, psychosocial support, etc.

There is no single outline for a community-based approach since each context of intervention is unique. Therefore, a qualitative analysis of socio-cultural determinants, involving all community members, is needed in each setting in order to design and agree on the best strategies.

This manual contains three parts:

Part I addresses concepts and general issues of the community approach as we understand it in MSF. It covers general explanations of culture, cultural access, community, and medical anthropology.

Part II describes the community-based approach step by step: from its planning to establishing contact with the community and implementation.

Part I and II provide guidance for the implementation of a community-based approach in a nutshell. For detailed information, please consult UNHCR (2008) “A community-based approach in UNHCR operations” and URD (2010) “Participation handbook for humanitarian and field workers, Part I-XI”.

Part III describes the tools that are needed for qualitative needs assessment, context analysis, and studies of socio-cultural determinants.

This guidance document is designed to help you feel more comfortable initiating a community-based approach according to MSF principles, values, and programme policies. It intends to explain the meaning of ‘community approach’ and the way it can be applied in the field. The document will assist you when using a community-based approach for your project.<sup>1</sup>

Any feedback to this guidance document is most welcome!  
Please address any comments to:  
[doris.burtscher@vienna.msf.org](mailto:doris.burtscher@vienna.msf.org).

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<sup>1</sup> Please note that all quoted examples are derived from international staff’s personal experience.

## List of acronyms

CA	community approach	TBA	traditional birth attendant
CHW	community health worker	ToR	terms of reference
CLTS	Community-Led Total Sanitation	UNHCR	United Nations High Commissioner for Refugees
DRC	Democratic Republic of Congo	URD	urgence, rehabilitation, développement
EC	expert client	VCT	voluntary counselling and testing
FGD	focus group discussion	WHO	World Health Organization
HBC	home-based care		
HP	health promotion		
HSB	health-seeking behaviour		
HTC	HIV testing and counselling		
IEC	Information, Education and Communication		
MoU	memorandum of understanding		
MSF	Médecins Sans Frontières		
NGO	non-governmental organisation		
OCB	Operational Centre Brussels		
OCBA	Operational Centre Barcelona-Athens		
ODF	open defecation free		
PHAST	Participatory Hygiene and Sanitation Transformation		
PSEC	patient support, education, and counselling		
RUTF	Ready-to-Use Therapeutic Food		
TB	tuberculosis		

# Part I – Community approach: concepts and issues<sup>2</sup>

## 1 What is a community?

‘Community’ can be described as a group of people who recognises itself or is recognised by outsiders as sharing common cultural, religious, or other social features, backgrounds, and interests. A community forms a collective identity with shared goals. However, what externally is perceived as a community might in fact be an entity with many sub-groups or communities. It might be divided into clans or castes or by social class, language, or religion.

For example, refugees and (internally) displaced persons living in temporary ‘communities’ often have different nationalities, religions, languages, ethnicities, and backgrounds, and do not perceive themselves as belonging to this ‘refugee community’ or to the whole group, but rather identify with their communities of origin.

In 2005, in the camps of internally displaced persons in Monrovia, Liberia, people from different communities from inside the country were living in the camp together for years but were still referring to the village of their home county. It was clear that these individuals considered themselves to belong to their places of origin and did not feel like members of this new community in the camp.

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<sup>2</sup> This section is adapted from (UNHCR 2008) and (URD 2010).

Whether they live in camps, in transit and reception centres, or in urban dwellings, lack of economic options, restrictions on the freedom of movement, and/or imposed decisions on accommodation often dictate who their next-door neighbours will be.<sup>3</sup>

## 2 Community-based approach and community approach

A ‘community-based approach’ is a way of working in partnership with people of concern during all stages of a programme cycle. It demands that we understand and consider the political context, the receiving population, gender roles, community dynamics, protection risks, concerns, and priorities. A community-based approach reinforces the dignity and self-esteem of people of concern and empowers all actors.<sup>4</sup>

‘Community approach’ or ‘community involvement’ in terms of MSF policies means to understand medical and paramedical needs in the community and to grant the population access to medical services in order to increase medical impact. To achieve this goal, MSF works closely with the communities of concern, taking into account that the approach to these communities differs according to the local context (Islamic countries, armed conflicts, natural disasters, etc.), country

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<sup>3</sup> (UNHCR 2008, 14)

<sup>4</sup> (UNHCR 2008, 14)

(African, Asian, Latin American, etc.), and the programme we are working in (violence, mental health, nutrition, HIV/AIDS and TB, etc.).

Therefore, qualitative cultural studies and assessments of the communities in question form a basic principle, which takes cultural perceptions of 'medical' needs, health, disease, illness, and access to healthcare into consideration.

In Addis Zemen, Ethiopia, during a session for pre-testing a leaflet, it turned out that a majority of persons tested we unable to identify the meaning of the pictures on the leaflet although we thought the pictures reflected their own communities and daily activities. This happened because we have been unconsciously trained how to perceive visual material and we usually assume that everyone else perceives it the same way.

In the context of community approach, it is important to differentiate between working IN the communities through outreach programmes, mobile clinics or small health posts, and working WITH the communities, which corresponds to the community approach described above.

Working WITH the communities means that the communities actively participate in medical and non-medical care provision (such as awareness raising sessions) by means of task shifting activities (e.g. diagnosis tasks such as HIV or malaria testing and providing ARV treatment in the communities). These tasks are carried out by CHW or HBC givers, who are sometimes (but not necessarily) already part of an MSF health promotion (HP) team.

Community approach in the MSF mental health project for Palestinian refugees in South Beirut implies approaching the communities through different NGOs inside and outside the camp. These NGOs are part of the community and this approach was chosen upon their request.

In its HIV/AIDS and TB project in Swaziland, community involvement is practiced through cooperation with the traditional chiefs in the rural areas, using the chiefdom's places for different activities such as community sensitisation, HP, and HTC. This was agreed upon the chief's request.

In Zimbabwe, community involvement was proposed to be implemented by working closely with the traditional healers to encourage their patients to go for voluntary counselling and testing (VCT).

In the Chadian context, MSF works in cooperation with a local NGO in a community approach to raise awareness of medical and social consequences and health risks of female genital cutting.

In Mozambique, MSF works with Community ART Groups (CAG). They facilitate monthly antiretroviral therapy (ART) distribution to other group members in the community (i.e., patients who have been stable for six months on ART), provide adherence and social support, monitor outcomes, and ensure that each group member undergoes a clinical consultation at least once every six months. (Decroo 2011)

### What may be MSF's motivation for a community-based approach?

- To ensure positive impact of MSF interventions
- To improve flexibility
- To help reduce or avoid negative impact of MSF interventions
- To increase the resources and expertise available for the project
- To enhance project relevance
- To improve project management
- To enhance project effectiveness
- To improve project efficiency
- To build relationships of mutual respect and understanding
- To support lesson learning
- To integrate the project into the social and institutional environment
- To improve the referral network
- To contribute to improved strategies (IEC, HP)
- To increase access to healthcare services
- To improve acceptance of our services

### 3 Concept of culture

Anthropologists have provided many definitions of culture, the most famous one being Taylor's definition in 1871: *"That complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society."*<sup>5</sup> Culture is a set of guidelines that individuals inherit as members of a particular society and

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<sup>5</sup> (Taylor 1889)

that tell them how to view the world, how to experience it emotionally and how to behave in it in relation to other people, to supernatural forces or gods and to the natural environment. To some extent, culture can be seen as an inherited 'lens' through which the individual perceives and understands the world that s/he inhabits and learns how to live in it.

### 4 Cultural access

Cultural access refers to the difficulty that outsiders may have in relating to a local community as a result of linguistic, behavioural, or other cultural challenges. This is of particular importance for international staff and international aid organisations but it is also relevant when national aid organisations come from a different area or social group than the affected population. Differences in social background, education, language, and accent, for instance, can all serve to create distance between aid workers and members of the affected population. Therefore, it is essential to work with one or more individuals who cannot only act as translators but also help you to interpret various signs and build 'cultural bridges'. It is important to have a good intermediary within the affected population, who can assist in contacting key stakeholders and groups.<sup>6</sup>

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<sup>6</sup> (URD 2010, chapter II, 56)



## 5 Participatory approach

Community participation describes the involvement of people in activities of common interest to achieve common goals. It is mostly voluntary and objective-oriented and implies working for a joint cause intended to enhance the welfare or development of the people. Solutions to problems are adapted to community capabilities and must be acceptable for all community members.

- In humanitarian situations, a participatory approach means involving people and communities in the humanitarian response in whatever way and to whatever extent possible in the given context.
- Participation can make a humanitarian response more efficient and effective, more relevant to real needs, and can help identify the most appropriate way of meeting those needs.
- People and communities can be involved in humanitarian responses directly on an individual level or indirectly via community representatives. In both cases, special care should be taken to ensure that the most vulnerable and socially marginalised people are included.<sup>7</sup>

In Yambio, South Sudan, the MSF ward for patients with sleeping sickness remained empty, although the existence of several cases in the community was known. When the communities were involved in the selection of new screening places, the number of cases treated in the ward increased drastically.

Since MSF is not a development organisation, the participatory approach depends not only on socio-cultural determinants but also on the security context (e.g., DRC, Somalia), on medical objectives (i.e., MSF will not necessarily treat cancer, even if the community sees it as a need), on means and resources as well as on the duration of the project.

When a community requests cancer treatment in the course of the opening of (any type of) health project, this request might indeed correspond to a real need. However, MSF will not necessarily respond to this need. MSF not only takes community needs into consideration when making its choices but also adapts decisions to MSF's identity, principles, priorities, and operational imperatives.

For further guidance consult URD (2010) "Participation handbook for humanitarian and field workers, Part I-XI".

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<sup>7</sup> (URD 2010, chapter I, 44)

## 6 Concept of medical anthropology

Being a medical humanitarian organisation, MSF considers medical anthropology an important factor in analysing different cultural contexts, their healthcare systems and people's health-seeking behaviour. These inherent elements play a fundamental role when thinking about a culturally appropriate community approach. *"Medical anthropology is about how people in different cultures and social groups explain the causes of ill health, the types of treatment they believe in, and to whom they turn if they do get ill."*<sup>8</sup> In all human societies, beliefs and practices relating to ill health are a central characteristic of culture. Often these are linked to beliefs about the origin of a much wider range of misfortunes (including accidents, interpersonal conflicts, natural disasters, crop failures, theft, and loss) and ill health is considered to be just one form of these conditions. In some societies, the whole range of misfortunes is blamed on supernatural forces, divine punishment or on the malevolence of a witch or a sorcerer. The values and customs associated with ill health are part of the wider culture and cannot be studied independently. One cannot really understand how people react to illness, death or other misfortunes without an understanding of the type of culture they have acquired or grown up in – that is, the 'lens' through which they perceive and interpret their world.

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<sup>8</sup> (Helman 2000, 1)

## 7 Why anthropology and medical anthropology for health sciences and community approach?

MSF will ask an anthropologist to conduct medical anthropological studies to analyse people's health-seeking behaviour, their perception of a certain disease or its treatment, etc. if the respective information is not available yet. Generally, medical anthropological analyses are needed when a HP programme is to be designed. Recommendations are formulated based on the analysis of the anthropological study and these recommendations then help develop HP messages for preventive intervention strategies.

Kiefer explains the relevance of (medical) anthropology for health sciences and community approach in so far as these disciplines

*"[...] provide health professionals with a set of tools for understanding health and illness according to the social perspective. This perspective is important because it shows the important relationship among health and culture, environment, economics, history and individual thought and action. Anthropology teaches us how to think about human lives and communities as complex systems of which health is just one integral part. It teaches us how to understand the unspoken assumptions, feelings, logic, and communication habits that people use in everyday life and in health practice."*<sup>9</sup>

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<sup>9</sup> (Kiefer 2007, 19)

In order to promote health and prevent disease, it is crucial to encourage a critical reflection on reality and to establish a dialogue with the people to discover together what could be the best for their well-being. People have different ways of understanding the world. To achieve that

“[...] it is important to know the ways in which people are now thinking and acting that may affect their health, and what kinds of new actions will make sense to them and help them accept changes. Anthropology offers a powerful, systematic way of understanding what aspects are affecting people’s health, and how to evaluate public health plans that affect people’s behaviour.”<sup>10</sup>

Sound knowledge of cultural issues is needed for MSF teams to approach extremely sensitive health-related issues such as traditional treatment of bodies in highly contagious epidemics (Cholera, Ebola, Marburg, etc.).

In Makoko, Nigeria, one of the reasons that prevented women from coming to the MSF health centre was that they thought MSF would keep the placenta for ritual uses or to cast spells.

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<sup>10</sup> (Kiefer 2007, 8)

## Part II – Step by step<sup>11</sup>

This section gives an overview of the different stages of the community-based approach, introducing assessment, context analysis, project design, the way to establish contact with the community, implementation, monitoring and evaluation as well as the definition of an exit strategy.

### Step 1: Assessment – understanding the context<sup>12</sup>

The main objective of an assessment is to get a comprehensive and integrated understanding of the context, the stakeholders involved, the problems faced by the people who are directly or indirectly affected, and the strategies that they have put in place in response to the situation/context. The information collected during an assessment needs to be continuously updated, complemented, and qualified by other sources and types of information. The assessment should include the perspective of a variety of groups within the population. For more detailed guidance, consult Koscalova (2012) “Assessment Toolkit, part I”.

MSF’s principles of impartiality, neutrality, and independence and how they are perceived will depend on who we engage with and in which way.

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<sup>11</sup> This section is adapted from (UNHCR 2008) and (URD 2010).

<sup>12</sup> Tools for assessments and qualitative studies are introduced on page 18.

In Jacmel, Haiti, religious leaders such as priests, pastors, imams, and voodooists were paying a lot of attention to who was visited first by MSF, as the order could be interpreted by some of them as a preference for one belief or another. This is why it is crucial to provide profound information about the MSF charter (concerning the principles of impartiality, neutrality, and independence, ethics, etc.).

In Beitbridge, Zimbabwe, community leaders were so committed to their people that they were willing to be trained in order to spread their knowledge among their communities.

The assessment is often the first encounter with the population and should be approached with the following in mind:

- Openly introduce yourself and facilitate a space for exchange.
- Analyse the context and its effects using a holistic approach (looking at the different aspects of culture and how they interact and why).
- Analyse and discuss needs and demands with the population.

When preparing the first field visit, inform the population in advance and organise a meeting with community leaders or elders.

- Be careful about your choice of intermediary and about who you engage with first as this will determine who you have contact with and may restrict your access to certain groups.

- Find out about rituals and traditions, respect them, and follow the recognised social hierarchy.
- During your first visit you have to introduce yourself, explain who you are and what you have come to do. Make sure your behaviour is conducive to mutual respect and open dialogue. Listen attentively and give people a chance to express themselves and to ask questions.
- Explain the purpose and the techniques you will use.
- Be careful about expectations you may be raising. Make sure that you clarify how you work and what you can and cannot do.

Understanding the context and the way populations perceive and organise their own lives in a given environment provides fundamental information for the analysis of problems and the identification of causal relationships. History, geography, environment, and culture fashion people's lives, the problems they face, and the way they respond to them.

Data on the geographical, social, cultural, and economic environment give us information about

- production activities and economic opportunities,
- social and cultural features (religious sites, main gathering places),
- access to education (schools),
- access to health (health centres, health posts, hospitals),
- geographical and environmental constraints.

Understanding a population's social organisation and culture entails covering a wide range of issues, many of which will have changed as a result of a crisis:

- culture, religious values, and practices,
- ethnic composition,
- gender relations,
- role of different age groups and the relationships between them,
- social hierarchies (e.g., based on caste, religion, ethnicity, language and wealth),
- languages.

**!** Try to describe your own society and culture as a way to start the discussion. Do not forget that humanitarian organisations in general and MSF in particular have a focused view of the context. While international staff stays a few months, the population has to deal with the difficulties on a regular basis.

### **'Real' versus 'perceived' needs**

A range of different factors influence the way people perceive needs. Culture, religion, livelihood and perception of the environment may be driving factors when expressing needs. Experiences during the crisis and any previous experiences of humanitarian aid will also play a role in the way people express their needs. A typical scenario is that a population will express a need for medical care when visited by a medical organisation. People often articulate their needs according to what they know or think you can provide.

## Expressed and unexpressed needs

Some needs may not be expressed, either because participants do not perceive them as needs, do not think they can be met or because they are embarrassed or do not dare to express the needs. Women, for example, may feel uncomfortable to talk about sexual and reproductive health to an assessment team. Hence, it is important to always have a balanced team including a woman.

In Swaziland, many people did not want to talk about HIV and AIDS in front of other family members or neighbours. Make sure to take these generally unexpressed requirements into consideration!

## Step 2: Establishing contact with the community

### Stakeholder analysis

This involves all individuals or groups who might be affected by a particular action and therefore have a particular interest in participating in the planning of activities or can influence an operation. Stakeholders include operational and implementing partners, national and local authorities, members of the community, such as community leaders and traditional chiefs, civil society (local NGOs, women's groups, human rights groups, etc.), school-board members, religious organisations, and host communities and their organisations.

→ Who will participate?

- Who will we work with? Individual members or community groups of the affected population?
- Grassroots community-based organisations?
- How do we tackle the risk of stigmatisation and human rights violations if collaboration with us provokes it?

→ How will we 'do' participation?

- What can be done to avoid discrimination of those who participate?
- How should the activities be implemented to ensure safety for the members of the affected population?<sup>13</sup>

### Insider vs. outsider community members

An insider is very close to a community or is from a community and has detailed knowledge of and experience in how the community works and what it has been through.

An outsider is a newcomer in a community and can help address problems without being influenced by local interests or becoming emotionally involved.<sup>14</sup>

### 1. Identify your partners

As a first step, mapping of the organisations in the geographical area and sector of operation (medical, etc.)

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<sup>13</sup> (URD 2010, chapter III, 82)

<sup>14</sup> (URD 2010, chapter III, 85)

should be considered to avoid duplication of activities and to find potential partners for collaboration and pooling of resources. This relates not only to NGOs but also to informal social entities, such as villages and women's groups.

## **2. Outline and communicate the principles of partnership**

Agree with your partners on

- shared interests in forming a partnership,
- shared understanding of the context and needs to harmonise perception of needs and demands.

Respect the autonomy of partners and be prepared to adapt your requirements to theirs!

## **3. Clarify the roles and responsibilities of each party**

- A partnership requires both or all parties to share responsibilities for managing and implementing the project.
- Resources should be mobilised by both partners.
- Who is involved in decision-making and on what issues?
- Who does what during project implementation and monitoring?
- Rules and sanction mechanisms need to be established.
- Ideally, each partner's roles should correspond to their area of expertise and their financial, managerial, and operational capacity and should also be realistic.

In DRC, MSF established a partnership with a local NGO to complement MSF's medical activities with socio-judicial support to victims of violence.

## **4. Establish a problem-solving mechanism**

Even if all roles and responsibilities are discussed and agreed on, differences of opinion between partners are likely to arise. It may be helpful to agree on a problem-solving mechanism, which should be context-specific and arranged and discussed with the parties involved.

In numerous African contexts, conflict resolution traditionally goes through a committee of elders, who sit together to discuss and decide on the solution to be pursued. MSF could agree on a committee for conflict resolution which should involve all parties.

## **5. Draw up a partnership agreement**

Put the partnership between the different parties in writing and include the terms of agreement. It is advisable to sign a Memorandum of Understanding (MoU) with any formal organisation, like local NGOs, while partnerships with communities can be based on a moral agreement. When there are no existing and recognised organisations, it is possible to support the creation of new organisations or committees to establish a high degree of participation and transparency.

It is important not to impose a form of organisation that is foreign to the local culture and will not be accepted by the affected population. To encourage the creation of new entities, it is important to draw on local cultural references, traditional consultation mechanisms, or other structures that the population can identify with.

### Step 3: Participatory project design

Before doing a participatory design, it is crucial to reach a common understanding with the people concerning the situation and problems to be addressed.<sup>15</sup>

In this phase, the information and findings from the assessment and qualitative study will be used and turned into potential programme objectives. Solutions are formulated based on the identified problems. Objectives for the community approach are then set according to the solutions.

#### 1. Prioritise objectives

According to the problem analysis and the defined objectives, a strategy of implementation will be defined. Before starting with the strategy, the objectives have to be prioritised:

- objectives people and communities are familiar with (due to usage in the past),
- objectives suggested by participants
- objectives that are feasible (SMART),

- objectives that complement local knowledge, practices and techniques.

Once you have analysed each objective according to the criteria set, you need to prioritise them, taking all the discussed elements into consideration. These decisions should be taken collectively to avoid problems at later stages.

#### 2. Define the project

Once the list of objectives has been established, the project strategy can be determined collectively. This step is crucial as you will define your commitments vis-à-vis the population. This step entails the clarification of

- project objectives (i.e., the problems the project will address),
- results or outputs of the project,
- indicators,
- the target group,
- activities that will be put in place to achieve the project results,
- resources needed to put these activities in place,
- who will do what and who will contribute what,
- the institutional set-up, management, and communication strategies.

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<sup>15</sup> (URD 2010, chapter VIII, 162)



In Swaziland, adolescents fear going to an HIV test because of the attached stigma. Therefore, it was mentioned in several interviews that HIV testing facilities could be in schools. If such voluntary testing is implemented in schools, the result might be that adolescents actually use these facilities and some may still not.

### 3. Define the target groups

The definition of objectives and results is related to the definition of the target group – the group who will directly benefit from the project.

! Organise a meeting on targeting with members of the communities as well as other stakeholders and authorities. Ask them to consider the following questions: Why do we target? Who will be targeted? How will we target?

Share the considerations behind the targeting process with the population, with local authorities, and other stakeholders.

- Be as efficient as possible at reducing suffering.
- Ensure that the most vulnerable people or groups are assisted.
- Make sure that the aid does not have any distorting effects.

In several projects where MSF was dealing with sex workers, it was hard to define what women perceived as being a sex worker. Therefore, they did not see themselves at risk.

In Beitbridge, Zimbabwe, one of the target populations for IEC activities were truck drivers, as they were the ones who refused to use condoms with sex workers.

### 4. Define activities and agree on contributions needed

Work out a project plan with the relevant stakeholders, specifying the resources needed for every activity: Who provides which resources? Who does what?

Coordinate the activities with other organisations and local initiatives to make sure not to undermine other activities and not to weaken the project by other strategies. Do not forget to plan trainings for participants, if needed.

In Swaziland in its HIV/Aids and TB project, MSF recently started to work with traditional healers to encourage patients to go for VCT. These healers received trainings by the MSF PSEC team.

- Define who does what and who contributes what.
- Make sure that community members and stakeholders have a genuine will and desire to participate.
- Try to check who really decides how people participate during the process.

- Ask yourself during the process if members of the population and local stakeholders have the capacity (in terms of time, material resources, and know how) to participate: What effects will participation have upon them? What sacrifices will they have to make in relation to their other activities, notably economic and social activities?
- Think about how you are going to motivate volunteers and define the incentives you are going to give to them or explain why you do not.

In Zimbabwe, MSF worked with HBC givers and provided them with bicycles to be able to move in the communities and to visit patients living far away from the HBC giver's home.

Women who collaborate with MSF as expert clients (EC) may at the same time be the only adult person in the household. Therefore, they are responsible for income and preparation of food. Make sure that activities within MSF do not prevent them from taking care of their children, for example.

In the HIV/AIDS and TB project in Swaziland, resources are shared in so far as community leaders and traditional chiefs provide and organise places for planned activities, like community sensitisation, HP, and HTC.

In Chad, where MSF has an outreach programme with mobile clinics, the communities provide and prepare the place for the distribution of RUTF and for the consultation of malnourished children.

## Step 4: Implementing the project

The first step of project implementation is to establish the general management framework and the relationships between the involved stakeholders. This is part of the project strategy and will be put into practice during implementation.

### 1. Human resources

When working directly with members of the community, it is important that people acting as intermediaries between MSF and the community are clearly identified and known to all parties. The same applies to groups the organisation deals with (women's groups, village elders, traditional healers, etc.).

### 2. Communication

Make sure to have clear and functional communication lines and that all parties agree with them. This concerns the organisation, project beneficiaries and members of the population, partners, relevant authorities, and stakeholders.

The means of communication should be culturally acceptable, effective, and accessible for the whole population. Pay attention to language as you may not speak the local language of the context you are working in. Be careful about choosing a translator who is accepted, sensitive towards gender and ethnicity and, if possible, unbiased AND train them.

Information is a source of power, so make sure the right information is provided to those concerned and that no one is excluded from the project process.

In Niger, MSF used local radio channels to raise awareness of the MSF programme and free access to healthcare. The radio was also used for HP messages, which were sometimes transformed into songs, etc.

In other contexts, MSF provided mobile phones to its partners to be able to communicate meetings and gatherings.

### 3. Recruiting and organising the project team

The high staff turnover may have a negative impact on participation by weakening cohesion between team members and the population. When recruiting team members, you need to ensure that people are well informed about the skills you are looking for, such as participatory skills and the ability to listen to and communicate with the population. Make sure that your team includes a good, gender-specific translator and represents different ethnic groups. You also need to be attentive to power relations in communities, as these may negatively influence the impact of the project.

### 4. Mobilising local resources

Using local resources like materials and services can stimulate local economies and support community members. Such materials and services may include, for example, producing red ribbon stickers or locally printed messages on T-shirts for HP activities.

## Step 5: Monitoring and evaluation<sup>16</sup>

Humanitarian projects rarely develop exactly as planned, and situations are always subject to change, sometimes very suddenly. Therefore, monitoring is very important.

When revising your participatory approach, consider the following questions:

- Who participated? Who did not participate?
  - List the different individuals and institutions or communities.
  - Did the latter ones represent the wider population?
  - Were any groups excluded?
  - Were some groups included unnecessarily?
- How did people participate and how effective was their participation?

In Morocco, MSF has '*agents de proximité*' (outreach workers). They originate in the same countries and speak the same languages as the trans-migrant target population. These workers are responsible for health promotion as well as for cultural mediation between the migrant target population and the Moroccan health facilities.

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<sup>16</sup> For more information and guidance on evaluation please refer to Kampmüller (2012) "Evaluation Manual: handbook for initiating, managing, and conducting evaluations".

## Step 6: Exit strategy

To ensure continuation of implemented activities, MSF has to define and deploy an exit strategy. This strategy should start soon after the opening of the project and the engagement with the community. It is crucial that MSF clearly decides what the organisation wants to leave behind and plan its exit accordingly with sufficient time and resources. Partially, the exit strategy can be realised through an agreement with the MoH (e.g., by forming a community committee and linking it with the MoH to guarantee recognition and future collaboration with MSF-trained CHW or HBC givers).

Ideally, a handover steering committee is created to oversee the action plan to follow up, ensure progress and continuously adapt the handover strategy to context changes. Three to six months before MSF intends to leave, the handover steering committee will assess the situation in terms of objectives and deadline. Where possible, a final post-departure evaluation will be conducted to learn from our good and bad practices.<sup>17</sup>

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<sup>17</sup> (MSF-UK 2011)

## Part III – Examples of tools and methods for community participation

### 1 Introduction to qualitative methods

Qualitative methods are commonly used to assess needs, understand problems, or evaluate interventions. Qualitative researchers aim to develop an in-depth understanding of human behaviour and the reasons that govern such behaviour. The qualitative method investigates the *why* and *how* of decision-making, not just the *what*, *where*, and *when*. Hence, smaller but focused respondent groups are needed more often than larger ones. Qualitative studies search for answers to questions that appear in the real world. They gather what they see, hear, and read from people, places, events, and activities.

The following chapters provide a short overview of qualitative research and its methods. More detailed information can be found in Koscalova (2012) “Assessment Toolkit, part I”.

### 2 What is qualitative research?

Qualitative methods are applied to understand behaviours and perceptions of affected communities. Unlike quantitative methods, which provide measurable answers to questions such as *how many*, *how often*, etc., qualitative methods answer the questions of *why* and *how*.

The purpose of qualitative research is to learn about certain aspects of the social world and to generate new understandings that can be used by the social world.

### 3 When to use qualitative methods?

#### Before planning

Before planning the community approach, qualitative methods help to define the target group of the community. Based on such research, the objectives of the intervention can be formulated.

#### During the project

We use qualitative methods during a project to evaluate or assess our community approach, to find out whether we meet the objectives and needs, and if the approach is appropriate to respond to the problems of the respective country. We also use qualitative methods if culturally related misunderstandings occur or more knowledge of culture and perception of the target population are needed. For example, from our quantitative data collection we may understand that women attend our clinics far less than we would expect but we do not know why. Qualitative research can help to answer such a question.

#### After the project

An evaluation can assess the intervention in question (implementation, design, results).

## 4 Getting started

In order to avoid duplication of research, keep the following points in mind before considering a study:

- Conduct a critical review of documents and literature
- What is already known? What are the gaps?
- Provide a rationale for your study – why is it important?
- Which methodological improvements of previous research are needed?

The process of getting started can be divided into three phases: formulating your question, writing the proposal, and selecting your participants.<sup>18</sup>

### Research Question

- Identify the right question and you are halfway there!  
WHAT is the question that you want to answer?
- In qualitative studies, the research question is critical as it shapes the design of the study.
- The research question should propose a solution for an operational need or dilemma.
- Question/s should not be too broad.

### Proposal

Write the proposal or terms of reference (ToR) and formulate general and specific objectives. Decide on the methods that will be used and elaborate the theoretical approach, data collection methods and data analysis methods.

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<sup>18</sup> Sampling methods are discussed in chapter 6.

### Pointers for the methodology

- Describe the methods you will use: number and type of interviews (taping, notes)
- Recruiting methods: include and justify the study location, the participants, and explain why they have been chosen
- Who will do the interviews?
- Scope of inquiry
- Ethics (consent, confidentiality)
- Translator
- Data collection
- Data analysis

## 5 Ethics

Four basic principles underline ethics:

- Respect for autonomy: respect the rights of the individual
- Beneficence: doing good
- Non-maleficence: not doing any harm
- Justice

Carefully consider the context you are working in and the sensitivity of the topic: Might the question be traumatising or make your respondent feel uncomfortable or fearful of consequences?

Two key ethical aspects have to be considered at all times:

- Consent: Everybody who participates should have freely consented without being coerced or unfairly pressurised. Participants should be well informed about what participation entails.
- Confidentiality is one of the most important principles of medical ethics. Qualitative research takes place in the field with real people who live and work in the setting. They are not anonymous to the researcher and if their identities are not protected, they may not be anonymous to anyone! Protect their privacy (identities, names and specific roles) and treat shared information confidentially (i.e., do not share it with others by using their names). Be sure that no unauthorised person can access your material.

### **Translator**

Choose your translator carefully and take time to brief him or her. Try to find a private place if this is appropriate. In many settings, you will need to match gender or ethnicity of interviewers and interpreters with those of interviewees.

### **Influence of culture and perception**

- Interpersonal communication
- Researcher – translator – participant
- Cultural background: values and beliefs
- Translator: gender, age, religion, power relations, status within the community
- Personal experience

Think about how two people of two different cultural backgrounds work together, what they have in common, what the differences could be, which ways of communication are used, acceptable, and appropriate.

For example, how do we (as MSF/as Western people) encounter a traditional authority in a Muslim country? Think about sensitive issues to be addressed, the possible influence of personal background, influence of gender, age and religion, importance of personal experience and the importance of working with a translator.

Even if the people you interview trust you, they might not trust your translator, especially if they believe the translator to be connected to one of the conflict parties or to a member of a different ethnic or religious group.

The translator is of major importance for the whole research. Take time to brief and train the person. Be adamant that s/he translates sentence by sentence, instead of giving you a summary. Brief the translator well about the reasons for and the risks of the interviews. The translator is outside the interview, s/he is a facilitator, and should not take the lead of the interview.

## **6 Sampling**

Samples for qualitative methods are usually purposive. Participants are selected because they are likely to generate useful data for the project.

You can create a sampling grid and recruit groups that reflect various combinations of variables, for example age (adolescents, adults, elderly), gender, income, rural/urban, ethnicity, etc.

A research study may keep interviewing until nothing new comes from the data – a point called saturation.

### Sample size

- Qualitative research does not provide a fixed number of participants to describe its sample.
- The objective is to gain information and insights from informant-rich cases (purposive sampling).
- Keep interviewing until you reach saturation!
- The informants are the 'experts'.
- Aim for quality, not quantity!

**!** The smaller the number, the more intense and deep the data being collected!  
Larger sample sizes are needed for heterogeneity, smaller sizes for homogeneity.  
Avoid sacrificing depth (length of interviews or number of interviews) for breadth (number of participants)!

For detailed information on various sampling methods, consult Kampmüller (2012) "Evaluation Manual: handbook for initiating, managing and conducting evaluations".

## 7 Information and data gathering

### 7.1 Individual interviews

#### Unstructured

This type of interviewing is used to explore the respondent's own perceptions and accounts. Unstructured interviews are of conversational character, which means that questions and topics are not decided in advance. Such interviews are used for topics with little knowledge and where it is important to gain an in-depth understanding.

#### Semi-structured

For semi-structured interviews, an interview guide or aide memories are used. Topics are specified but sequence and wording are flexible. This type of interview can be used when the researcher already knows quite a lot about the topic but wants to explore some precise areas within the topic.

#### Structured

In structured interviews, the exact wording is predefined and the sequence of questions is specified. The wording is open-ended.

### 7.2 Group interviews

#### Focus group discussion (FGD)

The focus group discussion is a group interview with a trained moderator, a specific set of questions, and a disciplined approach to study ideas in a group context.



Groups are generally composed of seven to ten people, who do not know each other well but share certain characteristics.

The researcher creates an open environment and asks questions that focus closely on one topic to encourage discussion and expression of differing opinions and points of views. The interaction among the participants is the critical characteristic of this type of interviewing.

The technique assumes that an individual's attitudes and beliefs do not form in a vacuum. The questions in a focus group setting are deceptively simple. The trick is to encourage participant to talk by creating a tolerant environment. People sometimes need to listen to other people's opinions and understandings to clarify their own.

Focus groups are formal and structured in that they are arranged for a fixed time and place.

### **Focus group discussion**

- Selection of participants according to sampling criteria
- Seeks a broad range of ideas about an open-ended topic
- Formal, controlled, pre-arranged time and place
- Usually audiotaped and transcribed for analysis

### **Natural group**

In contrast to FGDs, the natural group exists within the natural context of the research setting. Anthropologists and other field investigators often use natural group interviews as part of ethnographic data collection, both by design and pragmatic adaptation to community-based research. For

example, when conducting interviews in people's homes or public places, it is often difficult to restrict questions to a single individual because relatives or friends frequently join.

### **Natural group**

- Group exists independently of research study
- Formal or informal format
- Interview guide loosely followed
- Often recorded or written

### **Narrative group interviews**

Narrative group interviews can generate data of very high quality. The interpretation is done later. Especially in case of observations and in-depth interviews it is useful to have other information to support the interpretation. There still may be problems of group normalisation. Therefore, it is important to emphasise that accounts of, for example, people who had good and bad experience are needed.

### **Narrative group interview**

- Participants describe past experiences as a 'story'
- Each person contributes an account in turn
- Ask a volunteer to start
- Storytellers are not interrupted
- Discussion is allowed at the end

### 7.3 Participatory methods<sup>19</sup>

Participatory methods are often used in addition to typical interviews, as they can help to generate open discussions. They can be particularly useful with illiterate respondents and when participation (of the community) is crucial for the evaluation. Participatory methods require sufficient time.

#### **Time lines**

To do a time line, people (in groups or individually) are normally asked to think of important events within a given period in the past (e.g., during the project period). It can help to reconstruct history or understand changes.

#### **Mapping**

Drawing maps can be particularly useful in groups. They can serve to find out more about an area, about social features in an area, about changes in a particular area. Maps can demonstrate what important features for different respondents are (men, women, etc.). Mapping can be done on paper, on the ground using local resources, etc.

#### **Ranking**

There are many ways of ranking or ordering information (e.g., wealth ranking, problem ranking, impact ranking or performance ranking). Ranking can be used to identify differences in the community and to understand local indicators and criteria for wealth, health, etc. It can be done through voting to select a preference, pair wise to compare

which is the preferred of two options, etc. Performance ranking is particularly useful with staff to understand how they rank specific elements of a project, what worked, what is not working so well, and which improvements could be made.

#### **Transect walks**

Transect walks are similar to maps, but they are ambulatory and often partial (may not include the area of the entire village). Organised (or casual) walks through a particular area can help to identify important features for respondents and help to observe specific points. Walks can be more informal and ease discussions.

#### **Proportional piling**

Proportional piling can provide estimations about figures, shares, etc. The respondents are provided with a certain number of little units (e.g., 100 groundnuts, 20 pebbles of the same size or crushed paper) and asked to divide them according to the question (e.g., how many people out of your community take children to vaccination?). This helps to approximately quantify information and can trigger further discussion.

#### **Participant observation**

To fully understand the complexities of many situations, direct participation in and observation of the phenomenon of interest may be the best method. In most situations, there is not enough time to carry out a detailed observation but some observation will help as part of your daily work. The data collected must be descriptive so that the reader can understand what happened and how it happened.

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<sup>19</sup> This section is adapted from (Kampmüller 2012).

Observational data is also very useful to overcome discrepancies between what people say and what they actually do. Such data might help to uncover behaviour which the participants themselves may not be aware of. It is time-consuming BUT you can observe while doing interviews.

### **Participant observation**

- Deep understanding of cultural meanings and social structure of the group being studied
- Complex understandings
- Data collection through field note writing
- Time consuming – anthropological research

### **Community meetings, informal meetings, entry points**

Community meetings as well as informal meetings are an important way to be present in the communities and to get to know each other better. When community meetings take place and you, as an organisation, are invited, you should take this opportunity and participate in these meetings. Valuable information about social dynamics in the communities can be gathered in community meetings and informal meetings.

### **Community-action planning (e.g., workshops)**

Community-action planning means ‘participatory planning at the community level’, whereas the host community and other stakeholders can be included according to the circumstances. In this context, the community-action plan depicts how the community can and will go about the issues identified. At this

stage, it is essential to make sure that the interests of all different groups have been represented.<sup>20</sup>

### **SWOT analysis**

The SWOT analysis evaluates **S**trengths, **W**eaknesses/**L**imitations, **O**pportunities, and **T**hreats involved in a project. Current situations can be analysed to plan for the future and to make strategic decisions. Such an analysis can be part of the initial assessment as an input for the project proposal or serve as an evaluation exercise to get input about satisfaction and reorientation of activities.

A SWOT analysis workshop with the community can, for example, reflect on strengths, weaknesses, opportunities and threats which the communities believe affect their situation in terms of security, violence, nutrition, services, refugee community, health, etc. Such a workshop can be followed by a participatory reflection on recommendations and an action plan for the proposed project addressing some of the issues identified by the community in the SWOT analysis.

### **Community-based representations**

In order to get access to the wider community, it is crucial to communicate and work with the existing leaders – no matter what their positions or attitudes might be.<sup>21</sup>

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<sup>20</sup> (UNHCR 2008, 83)

<sup>21</sup> (UNHCR 2008, 61)

## 8 Validation of data<sup>22</sup>

Interviews may sometimes resemble everyday conversations, although they are focused on the interviewer's need for data. Furthermore, they are conducted in the most rigorous way to ensure reliability and validity (i.e., 'trustworthiness'). In that sense, validation of data becomes essential.

It is important to consider that the official community leaders are not always the most popular ones but the ones that have the politico-economic power. That is why it is important to get information from different sources to validate it.

There are three ways to guarantee the validity of data: triangulation, cross-checking of information, and reflection phases.<sup>23</sup>

## 9 Data management and analysis

If you decide to write a report about all the information gathered, please consider the following recommendations:

### **Recording/transcribing interviews**

You should take notes during or after the conversation, or audiotape and then transcribe the interviews.

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<sup>22</sup> This section is adapted from (Kampmüller 2012).

<sup>23</sup> For detailed information on validation methods, consult Kampmüller (2012) "Evaluation Manual: handbook for initiating, managing and conducting evaluations".

### **Analysis**

There are many different ways to analyse qualitative data. You can either use a thematic, descriptive approach, or more in-depth methods. In most situations, thematic analysis is sufficient.

A thematic analysis reviews all data to identify common or recurrent issues and identify main themes that summarise all the views you have collected.

### **Report writing**

According to your ToR, your data, and the analysis, you will write the concept of your report and finally the report itself.

#### **SAMPLE REPORT OUTLINE**

##### **Acknowledgements**

##### **Table of contents**

##### **Executive summary**

Should consist of a maximum of 1 to 2 pages and present main findings

##### **List of acronyms**

##### **Part I - Introduction and methodology**

Objectives, background, and methodology of the study

##### **Part II - Findings**

Findings according to the objectives

##### **Part III – Recommendations and conclusion**

Keep in mind that recommendations must be feasible!

##### **Annex**

Glossary, bibliography, work schedule, list of interviewees' profiles, maps, list of important contacts

## 10 PHAST or CLTS approach for health promotion

MSF works with the PHAST (Participatory Hygiene and Sanitation Transformation) approach when poor hygiene conditions lead to poor health. PHAST seeks to help communities to improve hygiene behaviours, prevent diarrhoeal diseases, and encourage community management of water and sanitation facilities. MSF only applies steps 2, 3 and 4 of the PHAST methodology; step 1 is usually done in the course of the assessment.<sup>24</sup>

The CLTS (Community-Led Total Sanitation) approach is an integrated approach to achieve and sustain an open defecation free (ODF) status. CLTS entails the facilitation of the community's analysis of their sanitation profile, their practices of defecation, and the consequences leading to collective action to become ODF. CLTS does not apply an approach in which outsiders 'teach' community members. It focuses on igniting a change in sanitation behaviour (rather than constructing toilets) through a process of social awakening that is stimulated by facilitators from within or outside of the community.<sup>25</sup>

<sup>24</sup> (WHO 1998)

<sup>25</sup> (Kar and Chambers 2008)

## Steps in PHAST<sup>26</sup>

Step	Activity	Tool
<b>Step 1</b> Problem identification	<ol style="list-style-type: none"> <li>1. Community stories</li> <li>2. Health problems in our community</li> </ol>	<ol style="list-style-type: none"> <li>1. Unserialised posters</li> <li>2. Nurse Tanaka</li> </ol>
<b>Step 2</b> Problem analysis	<ol style="list-style-type: none"> <li>1. Mapping water and sanitation in our community</li> <li>2. Good and bad hygiene behaviours</li> <li>3. Investigating community practices</li> <li>4. How diseases spread</li> </ol>	<ol style="list-style-type: none"> <li>1. Community mapping</li> <li>2. Three-pile sorting</li> <li>3. Pocket chart</li> <li>4. Transmission routes</li> </ol>
<b>Step 3</b> Planning for solutions	<ol style="list-style-type: none"> <li>1. Blocking the spread of disease</li> <li>2. Selecting the barriers</li> <li>3. Tasks of men and women in the community</li> </ol>	<ol style="list-style-type: none"> <li>1. Blocking the routes</li> <li>2. Barriers chart</li> <li>3. Gender role analysis</li> </ol>
<b>Step 4</b> Selecting options	<ol style="list-style-type: none"> <li>1. Choosing sanitation improvements</li> <li>2. Choosing improved hygiene behaviours</li> <li>3. Taking time for questions</li> </ol>	<ol style="list-style-type: none"> <li>1. Sanitation options</li> <li>2. Three-pile sorting</li> <li>3. Question box</li> </ol>
<b>Step 5</b> Planning for new facilities and behavioural change	<ol style="list-style-type: none"> <li>1. Planning for change</li> <li>2. Planning who does what</li> <li>3. Identifying what might go wrong</li> </ol>	<ol style="list-style-type: none"> <li>1. Planning posters</li> <li>2. Planning posters</li> <li>3. Problem box</li> </ol>
<b>Step 6</b> Planning for monitoring and evaluation	<ol style="list-style-type: none"> <li>1. Preparing to check our progress</li> <li>2. Checking our progress</li> </ol>	<ol style="list-style-type: none"> <li>1. Monitoring (checking) chart</li> <li>2. Various tool options</li> </ol>

<sup>26</sup> Adapted from (WHO 1998)

# Annex

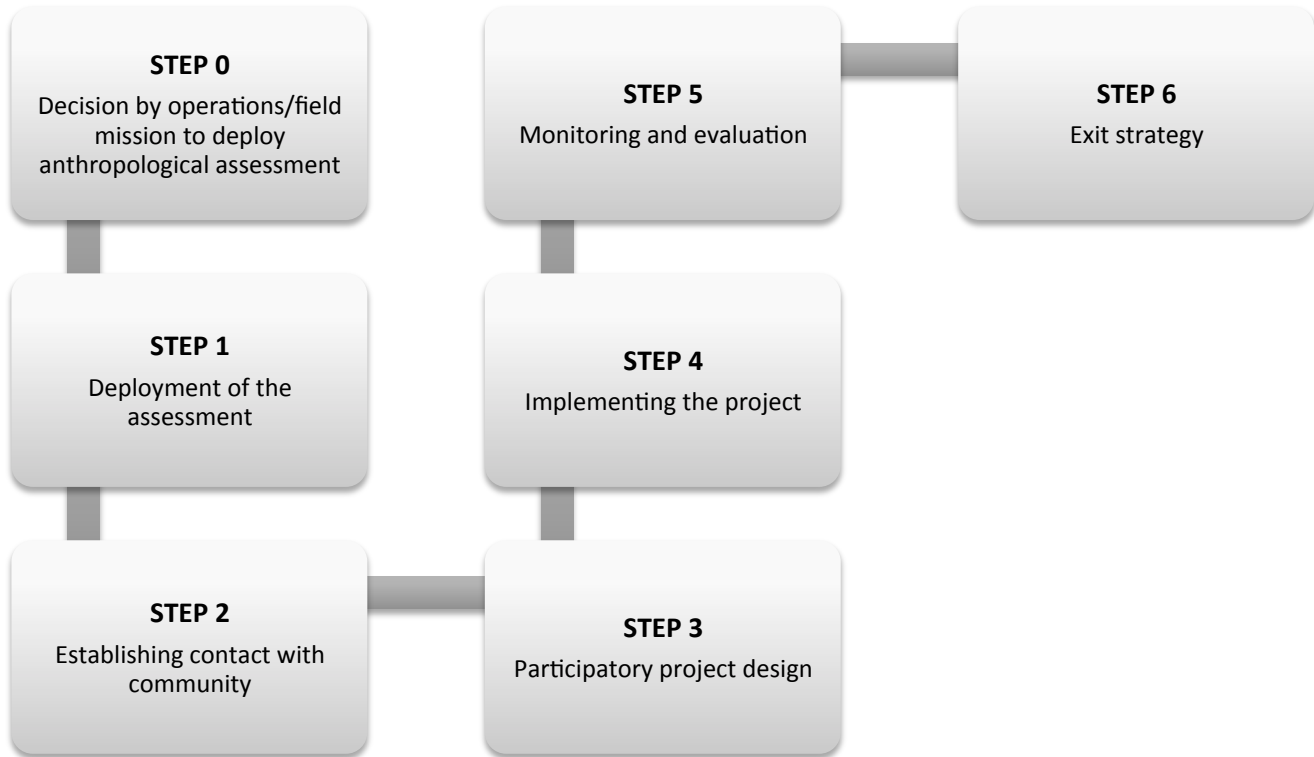
## 1 Basic considerations for community approach<sup>27</sup>

<b>Key persons and contacts</b>	<ul style="list-style-type: none"><li>→ Who are the key contact persons in the community?</li><li>→ Who are the key contact persons/representatives of each social unit? What are their tasks in the community (e.g., distribution of goods, water; legal representation; negotiation with police)</li><li>→ How important is the role of community leaders?</li><li>→ Who else (besides leaders) enjoys a high reputation? (healers, herbalists, priests, rich men, trained and untrained TBAs)</li><li>→ How reliable are my contacts? Who can serve as backup?</li><li>→ Is a top-to-bottom approach the best way to reach my target group? Is it possible to interact with the community without permission of an authority? (Do people show fear? Would the community head endanger my project if I do not involve him in every decision?)</li><li>→ Who could work as my local guide/interpreter?</li><li>→ What are the implications for community members when they have close contact with foreigners?</li></ul>
<b>Community structure</b>	<ul style="list-style-type: none"><li>→ How is the community organised? (Clans, larger family units, moieties, royal families, big men, council of elders)</li><li>→ Is the community administered autonomously (traditional leaders), by the municipality, or both? Which system is more influential?</li><li>→ How many different groups live in one community? (ethnically homogeneous/heterogeneous)</li><li>→ Are there frictions in the community (ethnically, religious, political, economic, etc.)</li><li>→ How are conflicts dealt with? (internal mitigation; traditional conflict resolution mechanisms; police → reliability/efficiency of police)</li><li>→ Who are the marginalised people in the community? (female-headed households, unaccompanied children, disabled, sick, elderly, ethnic minorities, etc.) Do they have specific needs?</li></ul>

<sup>27</sup> Compiled by Paul Grohma

<b>Identity</b>	<ul style="list-style-type: none"> <li>→ What makes your community a community? (delineation from other communities – through origin, language, descent, occupation, religious identity, etc.)</li> <li>→ What is the background of the community? (urban, rural; newly arrived, long-established)</li> <li>→ Who was here first? (migrant communities and their relationship to the host community)</li> <li>→ What is the status of the community? (marginalised, integrated, dependent of others)</li> <li>→ How does the municipality see/treat the community? (support, neglect, trying to get rid of them)</li> <li>→ Community's attitude towards humanitarian organisations (in general and knowledge about MSF)</li> <li>→ How does the community interact with others? (trade, having a certain function in the urban setting)</li> <li>→ Are there conflicts within the community or with neighbouring communities? (land, shelter, economic opportunities, scarcity of resources/marriage partners)</li> <li>→ What are the major economic activities in the community and what is the level of the average working activity? (low/medium/high)</li> <li>→ Movements: How mobile is the community/parts of the community? What are daily/weekly/seasonal movements? (stationary community with little contact to surrounding communities/migrant workers with daily routines outside their area of residence/shifting communities with seasonal changing habitats)</li> </ul>
<b>Community health</b>	<ul style="list-style-type: none"> <li>→ What are the basic health needs of the community? What are the most common diseases?</li> <li>→ What is the current situation of the community? (it's always like that/it's worse than ever/we're better off than ten years ago)</li> <li>→ Food situation: What is the basic staple food in the region? Where does food come from? Are there seasonal fluctuations? Are the providers from within the community or from outside? Proximity and frequency of the market? How reliable/changing are the prices? Has food other important functions? (religious; necessary for rituals)</li> <li>→ Nutrition/cooking: What is the main cooking technique in the community and how are stoves fuelled (wood, charcoal, electricity; expenses for cooking/fuel)? How many meals a day?</li> <li>→ Average purchasing power: enough money to buy food, cloths, sanitary products, drugs and pay for medical services?</li> <li>→ Gender-based violence</li> <li>→ Health-seeking behaviour</li> <li>→ Birthing practices, pregnancy planning, family planning</li> </ul>

## 2 Key steps for community involvement





### 3 Definitions

<b>Anthropology</b>	Anthropology tries to achieve an understanding of culture, society and humanity through detailed studies of local life, supplemented by comparison. (Eriksen 2004)
<b>Medical anthropology</b>	Medical anthropology is about how people in different cultures and social groups explain the causes of ill health, the types of treatment they believe in, and whom they turn to if they get ill. (Helman 2000)
<b>Culture</b>	“Culture is common knowledge and meaning shared with others. [...] Culture is constantly being recreated over and over again and is constructed between people. [...] Every individual can participate in many different social categories and should therefore not only be portrayed as a national category, but also in categories such as gender, education, social background, age etc.” (Jensen 2008) The author emphasises the fact that culture is not supposed to be described as a national characteristic only and an individual cannot be seen as representative for a society. She describes culture as complex, dynamic processes, which are constantly changing and being recreated by people.
<b>Cultural access</b>	Cultural access concerns the difficulty that outsiders may have in relating to a local community as a result of linguistic, behavioural, and other cultural barriers. (URD 2010)
<b>Community</b>	A community is a group of people that recognises itself or is recognised by outsiders as sharing common cultural, religious, or other social features, backgrounds, and interests. It forms a collective identity with shared goals. (URD 2010)
<b>Community based approach</b>	This approach is a way of working in partnership with persons of concern during all stages of a programme cycle. (UNHCR 2008)
<b>Community involvement</b>	Community involvement is the process of engaging in dialogue and collaboration with community members.
<b>Participatory approach</b>	Participatory approach means involving crisis-affected people in the humanitarian response in whatever way and to whatever extent possible in a given context. (URD 2010)
<b>Health promotion (HP)</b>	Health promotion is the process of enabling people to increase control over and to improve their health. WHO Health Promotion is a set of activities of health education and health services improvement that are intending to develop better the use of healthcare services (patients & population). (Loots 2009)
<b>Population HP approach</b>	This approach is focusing on communities to promote our health structures and to control the epidemics in the population. (Loots 2009)
<b>Patient HP approach</b>	This approach is focusing on patients and on the adaptation of healthcare to the cultural behaviours and practices of the population where we are working. (Loots 2009)
<b>Information, Education and Communication</b>	In health programmes, this approach aims to increase awareness, change attitudes, and bring about a change in specific behaviours. IEC means sharing information and ideas in a way that is culturally sensitive and acceptable to the communities using appropriate channels, messages, and methods. (In MSF, HP and IEC are used interchangeably).

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Notes

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**Written by Doris Burtscher**

**Edited by Sandra Bauer**

**Contributions by Eva del Rio, Hani Fares, Olivia Hill, Paul Grohma, Pedro-Pablo Palma, Petra Haderer, Sabine Kampmüller, Sandra Cavaco, Valerie Minne, Yasmine Al Kourdi**

**MSF-OCG, Vienna Evaluation Unit**

**<http://evaluation.msf.at>**

