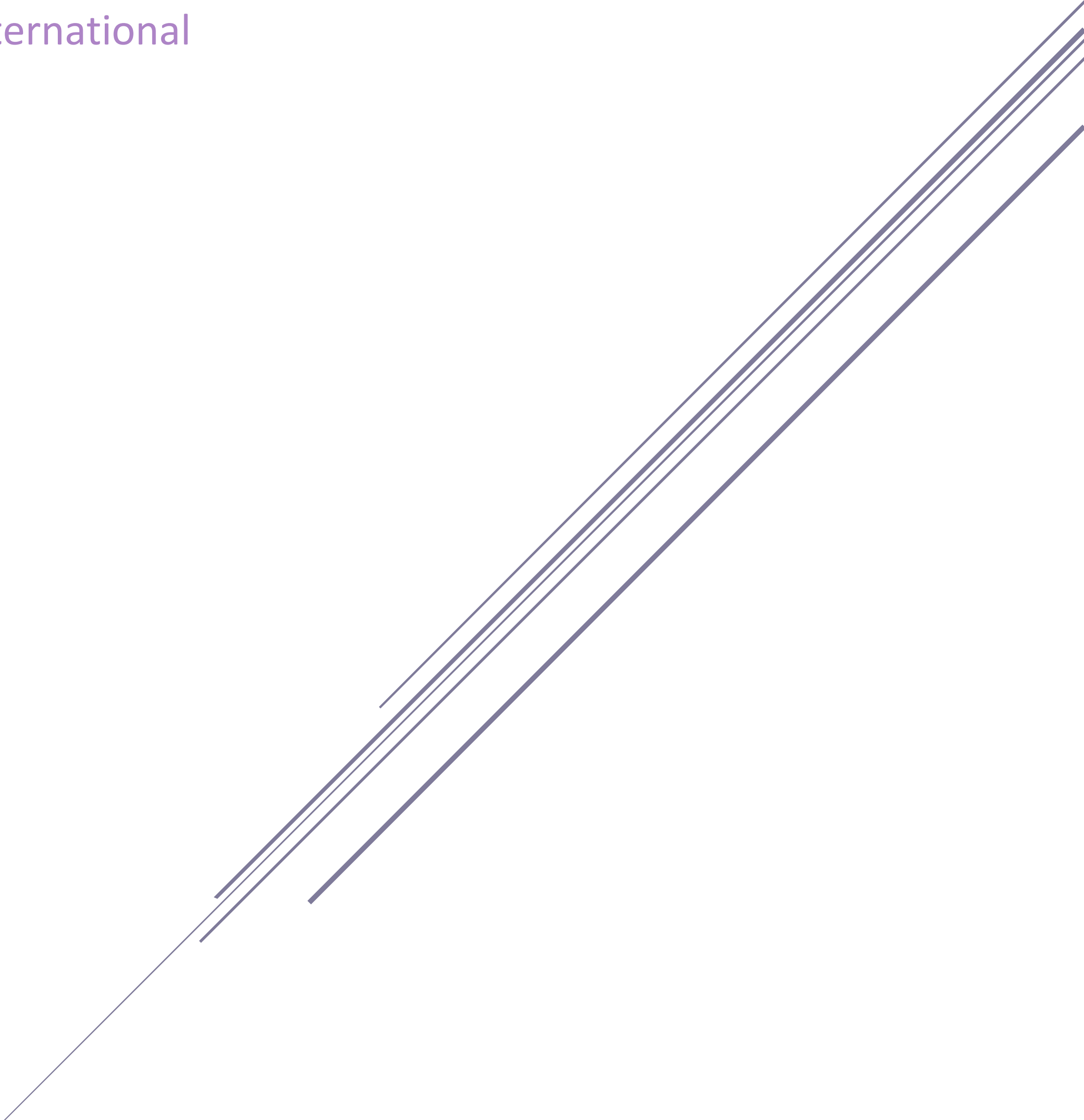
THE COMMUNITY READINESS TO CHANGE APPROACH: A GUIDE FOR ORGANISATIONS WORKING ON PERIOD EQUALITY INITIATIVES

Irise International



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The Community Readiness to Change Approach: Learning from Irise Institute East Africa

Overview

This handbook provides a step-by-step guide to using the Community Readiness to Change Approach (CRCA) in menstrual health based on Irise Institute East Africa's own experience of using of the approach.

The CRCA was developed as part of a community-based behaviour approach designed to contribute to the end of female genital cutting (FGC) in Europe[1]. In many ways, social norms surrounding FGC are like those surrounding menstruation. How people experience menstruation is shaped by community-level taboo and stigma in much the same way as individuals experience social values around FGC.

The CRCA evaluates a community across six dimensions of change – listed in the green box in figure 1. Each dimension is then scored from 1-9 based on the categories outlined in the red box in figure 1. A community's stage of readiness to change (red box) gives an insight into where the community is in terms of progress towards changing a social norm. This information can then be used to help design menstrual health interventions and contribute to the dismantling of the menstrual stigma – a key part of effective interventions.

	Dimensions of Community Readiness
A	Community knowledge concerning menstruation
B	Community belief systems and attitudes towards menstruation
C	Community efforts to improve menstrual health
D	Community knowledge of efforts to improve menstrual health
E	Community leaders' and influential peoples' attitudes to improve menstrual health
F	Community resources available to support efforts to improve menstrual health

Stages	*Community Readiness to Achieve Period Equality*
1	**NO COMMUNITY AWARENESS:** Menstrual health is not viewed as an issue
2	**COMMUNITY DENIAL/RESISTANCE:** Some community members recognise menstrual health as an issue
3	**VAGUE COMMUNITY AWARENESS:** Many have concerns about menstrual health but no community motivation to change
4	**PREPLANNING:** Community recognition that something must be done about menstrual health, but efforts lack focus
5	**PREPARATION:** Community leaders begin planning in earnest to achieve period equality in the community
6	**INITIATION:** Community activities and interventions underway to achieve period equality
7	**STABILISATION:** Community leaders support achieving period equality in their community
8	**EXPANSION:** Community members feel comfortable with achieving period equality
9	**COMMUNITY OWNERSHIP:** High level of community buy-in to achieve period equality which becomes the social norm

Figure 1: Dimensions of Change and Readiness to Change Model (Adapted from the REPLACE toolkit)

Step 1: Recruiting Community Based Researchers

Community-based researchers should be recruited from target communities to help encourage community ownership of all project activities and outcomes.

Figure 2 shows the key skills and characteristics of community-based researchers. Ideally, two male and two female community-based researchers should be recruited per community. These individuals must be trained in the community readiness to change approach so that they understand what is expected of them. This handbook is a useful starting point for this training. Organisations can also draw on the full handbook designed to end FGC in Europe, available here.

These community-based researchers will be leading the assessment activities, detailed in step 3.

Key Characteristics of Community-based Researchers

- ✓ A member of the target community
- ✓ Respectable and influential in the target community
- ✓ Has an interest in menstrual health
- ✓ Sympathetic and enthusiastic about period equality
- ✓ Has good knowledge of the target community, including the cultural, politics, social, and economic life of the community
- ✓ Understands the local language
- ✓ Has good communication, social, and organisational skills
- ✓ Has good knowledge of menstrual health
- ✓ Qualitative research skills (this is not essential but desirable)

Figure 2: Key characteristics of community-based researchers. (Source: REPLACE toolkit[2], page 44)

Step 2: Recruiting Community Members

Representatives of the community should be identified and recruited to take part in community readiness to change assessment activities.

These people should represent different parts of the community including:

- Men and women (all participants should be over 18 years old)
- Different generations (unmarried, newly married but with no children, parents with young children, grandparents)
- People with different roles within the community (such as religious and community leaders)
- Length of time the person has been living in the community (such as established members of the community and those recently arrived)

It is recommended that 15-20 people are recruited. These individuals must be fully informed about the project's goals and give their consent to be involved in assessment activities before they begin, ideally in writing. An example of a participant information sheet that can be given to participants is provided at the back of this handbook (resource 1) as well as an example consent form (resource 2)

Step 3: Facilitating Focus Group Discussions and/or Interviews

Community-based researchers should decide whether they will undertake focus group discussions, or several community readiness interviews with individual people, and conduct them with community members.

This decision will be affected by time and resource constraints.

If undertaking focus groups, it is best to have separate focus groups for different genders and/or age groups and have a female researcher leading female only groups and a male researcher leading male only groups. Ideally, focus groups will consist of 6-10 people.

It is best if two researchers are assigned per focus group: one researcher should ask the questions and the second should write down the responses to the questions by group members as accurately as possible and avoid entering the discussion unless something someone else said is unclear. If possible, focus groups and interviews can be recorded and the second researcher could transcribe them (i.e. listen to the recordings and write everything everyone says down).

There are some key things for researchers to consider when facilitating an interview or focus group:

- The venue for interviews and/or focus groups should be local to participants and accessible to everyone.
- The date and time of the interview and/or focus group discussion should not conflict with important community events.
- If possible, ensure that seating is arranged in a circle as this creates a better atmosphere for interaction between individuals.

A recommended interview/focus group discussion framework is provided in the resources at the back of this handbook (resource 3). There are 24 questions to be asked in total. The focus groups/interviews should take about 30-60 minutes to complete.

Step 4: Scoring the Community

After the interviews and/or focus groups have taken place, all the notes that were taken for each group should be gathered together. Ideally, two members of staff should separately review this material and score each interview and/or focus group. This can be done using the scoring form included in the resources at the back of this handbook (resource 4). It is important that the staff members do this apart from each other, so they are not influenced by the others' opinion.

The score given for each dimension (A-F) on the scoring form should use the following information:

Dimension/Score	1	2	3	4	5	6	7	8	9
A: Community Knowledge of MHM	MHM is not viewed as an issue.	No knowledge about MHM	A few people in the community have some knowledge about MHM	Some community members know about the education and health impacts but information is lacking.	Community knows that support for MHM is inadequate and general information is available.	A majority of community members know about the health and education impacts of inadequate MHM and recognise it as a problem within their community.	Community have knowledge of and access to detailed information about MHM in their community.	Community members of knowledge about MHM in their community and understand the consequences and impact of inadequate provision.	Community has detailed information about MHM in their community, as well as information about the effectiveness of local interventions and activities to improve it.
B: Community Belief Systems and Attitudes Towards MHM	The prevailing attitude is that MHM is not considered and is not commented on in the community.	The prevailing attitude is that there is very little we can do to improve MHM for girls or that it only affects "those people."	The community is neutral, disinterested or believes inadequate MHM does not affect the community as a whole.	The attitude in the community is now beginning to reflect an interest in improving MHM. "We have to do something, but we do not know what to do."	The community are concerned about MHM and community members are beginning to reflect modest support efforts to improve MHM.	The community believe it is their responsibility to improve MHM and are beginning to get involved in efforts to improve MHM.	The majority of the community supports efforts to improve MHM.	Some community members or segments challenge specific activities or interventions, but in general are strongly supportive of the need for activities and interventions to improve MHM.	All segments of the community are highly supportive and community members are actively involved in evaluating and improving MHM efforts.

C: Community Efforts to Improve MHM	No awareness of efforts to improve MHM.	No efforts addressing the issue.	A few individuals recognise the need to initiate some type of effort to improve MHM, but there is no immediate motivation to do anything.	Some community members have met and have begun a discussion of developing community efforts to improve MHM.	Efforts to improve MHM are being planned.	Efforts to improve MHM have been implemented.	Efforts to improve MHM have been running for several years.	Several different activities/ interventions are in place, covering different segments of the community and reaching a wide range of people. New efforts are being developed based on evaluation results.	Evaluation is routinely used to assess the effectiveness of different efforts to improve MHM and the results are used to make changes or improvements to activities.
D: Community knowledge of efforts to improve MHM	Community has no knowledge of the need for efforts to improve MHM.	Community has no knowledge of efforts addressing MHM.	A few members of the community have heard about efforts to improve MHM but their knowledge is limited.	Some members of the community know about efforts to improve MHM.	Some members of the community have basic knowledge about initiatives to improve MHM.	An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts.	There is evidence that the community has specific knowledge of local efforts to improve MHM including who to contact concerning MHM.	There is considerable community knowledge about different community efforts to improve MHM as well as the level of activity/ intervention effectiveness	Community knowledge on activity/ intervention evaluation and on how well local efforts to improve MHM are working
E: Community Leaders' and influential people's attitudes to improving MHM	Community leaders and influential people do not recognise MHM as an issue.	Community leaders and influential people do not believe MHM is an issue.	Community leaders and influential people recognise the need to do something to improve MHM.	Community leaders and influential people are trying to get efforts started to improve MHM.	Community leaders and influential people are members of committees, groups and organisations that are improving MHM in the community	Community leaders and influential people are active and supportive of efforts to improve MHM.	Community leaders and influential people are supportive of continuing basic efforts to improve MHM and are considering what resources are needed from the community.	Community leaders and influential people support expanding and improving efforts to improve MHM through active participation	Community leaders and influential people are continually reviewing evaluation results of efforts to improve MHM and are modifying support accordingly

F: Community Resources available to support efforts to improve MHM.	There is no awareness of the need for resources to improve MHM.	There are no resources available to improve MHM in the community.	The community is not sure where to get resources to begin efforts to improve MHM.	The community has volunteers, organisations and/or space available that could be used as resources.	Some members of the community are actively investigating how to get resources.	Resources have been obtained and/or allocated to improve MHM in the community	A considerable part of the support for on-going efforts to improve MHM come from community resources. Community leaders and influential people are trying to access additional resources	Different resources and funds have been secured for existing efforts to improve MHM and additional support has been secured for future activities and interventions.	There is continuous and secure support for activities and interventions to improve MHM in the community. Evaluation is routinely undertaken and there are resources for trying new activities and interventions

Figure 3: Community Readiness to Change Reference Table

Once this activity has been completed by staff members, the scores for each dimension (A-F) can be recorded to provide insights into each area of interest.

A total community readiness to change score **for the focus group/interview** can be calculated using the scoring form in resource 4.

A total community readiness to change score **for an entire community** can also be calculated using resource 5. The final score that you calculate will range between 1-9 and is the **community readiness to change score for that community.**

NB: It may also be useful to calculate average scores across all 6 dimensions (A-F) for each community. This approach is used in Irise's evaluation toolkit. To do this, take each dimension (A-F) individually and calculate the average score for all 6 dimensions across focus group/interview data. For example, for dimension A: Community knowledge of MHM, add together all scores given for dimension A and divide by the number of focus groups/interviews undertaken.

Step 5: Using the Community Readiness to Change Score

Once a community has been scored, this score can be used to inform the focus of intervention design using the table below (figure 4).

Dimensions of Change	Low(1-5)								
	Medium (4-6)								
	High (7-9)								
A. Community Knowledge of Menstrual Hygiene Management (MHM)									
B. Community belief systems and attitudes towards MHM									
C. Community Efforts to improve MHM									
D. Community Knowledge of the Efforts to Improve MHM									
E. Community Leader's and Influential People's attitudes to improving MHM									
F. Community Resources Available to Support Efforts to improve MHM									
Stages of Community Readiness to end menstrual related discrimination	1	2	3	4	5	6	7	8	9
	No community awareness	Community denial/ resistance	Vague community awareness	Preplanning	Preparation	Initiation	Stabilisation	Expansion	Community ownership
Focus of Intervention	Increasing knowledge of MHM			Changing attitudes and initiating behaviour change concerning MHM			Supporting behaviour change		
	-building community cohesion -increase knowledge of health & education impacts -Challenge belief systems underpinning menstrual taboos and subsequent neglect			-identify and support community leaders/champions -Support efforts by developing appropriate interventions - Begin to harness community resources			-reinforce community efforts -Continue to harness community resources		
Social Norm Change	Social norm supporting neglect of MHM			Social norm tipping point			Social norm supporting MHM		

For example, if a community receives a community readiness score of 1-3…

…then interventions should be focused on increasing knowledge of menstrual health by building community cohesion, increasing community knowledge of health and education impacts, and challenging the belief systems underpinning menstrual taboos.

Figure 4: Community Readiness to Change model

Intervention Function	Definition	Example of intervention function
Education	Increasing knowledge or understanding	Providing information to encourage parents to talk to girls about menstruation.
Persuasion	Using communication to generate positive or negative feelings or stimulate action	Using drama (e.g. radio skit) to encourage increases in physical activity.
Incentivisation	Creating an expectation of reward	An award for the most "menstruation friendly" school at the end of a project.
Coercion	Creating an expectation of punishment if changes are not seen	Schools who fail to make changes receive less funding/support for future activities.
Training	Imparting skills	A course for teachers about how to teach girls and boys about menstruation.
Restriction	Using rules to encourage people not to do a certain behaviour	Rules for use of school toilets - no boys allowed near the girls' toilets.
Environmental restructuring	Changing the physical or social context	A sign in the school office reminds teachers of 3 ways they can support girls during their periods.
Modelling	Providing an example for people to aspire to	Using a celebrity talking about their experiences of menstruation to encourage positive attitudes.
Enablement	Increasing means/reducing barriers to increase capability or opportunity (beyond education and training and environmental restricting)	Menstruation clubs in schools where peer to peer mentorship is facilitated.

Figure 5: Different ways to encourage change in target community

Figure 5 explains different things that intervention projects can focus on to generate change.

Organisations can decide which function would work best for their intended outcomes.

Step 6: Evaluating Progress Using the CRCA

Organisations can repeat the process of scoring a community later to see whether intervention activities have encouraged change.

This information can then be used to demonstrate the impact of the project and adapt project activities to be more effective.

For example, if during the first iteration of the community readiness to change approach a community scores 3 and a second time a community scores 5, progress has been made towards changing social norms around menstruation as a community has moved from 'social norm supporting neglect of MHM' to 'social norm tipping point' (see figure 4). This information can be used to demonstrate improvement and inform the design on the project moving forward

Resource 1: Example Participant Information Sheet

(Adapted from the REPLACE toolkit[1], page 31)

About *[enter the name of your organisation]*
Include some information about your organisation including your mission.

What is the purpose of this project?
The aim of this project is to find out about beliefs regarding menstruation in *[insert community name]* and whether menstrual health is seen as an issue.

Why have I been chosen?
You have been asked to take part because you are connected with the *[insert community name]* community and we are interested in what you have to say.

Do I have to take part?
Participation in this research is voluntary and if you change your mind you can withdraw at any time without giving a reason.

What will happen to me if I take part?
You will be asked to attend a *[focus group or interview]* consisting of no more than eight other people of the same sex. The meeting will take place at a location convenient to you. The focus group may be recorded, or detailed notes written down. At the end of the conversation, the facilitator of the focus group will de-brief you and you will be given an opportunity to ask questions and discuss matters relating to your participation.

What are the possible disadvantages and risks of taking part?
There is a time cost as we will ask you to give up some of your time to take part in the project. You may also find some of the subjects difficult or uncomfortable to talk about. You do not have to talk about personal experiences unless you want to, and you can stop the discussion any time if you do not wish to continue.

What are the possible benefits of taking part?
By taking part in the focus groups or interviews you will have the opportunity to have your say about the important issue of menstrual health.

What if something goes wrong that I am not happy about?
If there is anything you are unhappy about, please let a staff member from *[insert name of your organisation]* know.

Resource 2: Example Participant Consent Form

(Adapted from the REPLACE toolkit[1], page 33)

Title of Project: ______________________________

Please tick the following boxes for each statement:

1. I confirm that I have been informed about the community readiness to change approach and understand the project being facilitating by *[enter your organisation].* ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time from the project without giving any reason. ☐
3. I understand that my responses will be anonymised before the information I provide is analysed. I give permission for the researcher and the research team *at [enter your organisations name]* to have access to my anonymised responses. ☐
4. I consent to the interview/focus group I am involved in being recorded and written down. ☐

________________________	________________________	___________________________
Name	Date	Signature

Resource 3: Community Readiness to Improve MHM: Interview/Focus Group Questions

Dimension A: Community Knowledge of Menstrual Hygiene Management (MHM)

A1: How knowledgeable are members of your community on the issue of MHM? Is it viewed as an issue? Are some members of the community more knowledgeable than others? Please give examples.

A2: What information is available about MHM in your community and through what channels? Please give examples.

A3: Do people know about the education and health aspects of MHM and where do they get this information from? Please give examples.

A4: On a scale of 1-9 (with 1 being very low and 9 being very high) how knowledgeable is your community about MHM?

Dimension B: Community belief systems and attitudes towards MHM

B1: Does your community support changing current MHM for girls? Why and how?

B2: What are the main obstacles to changing MHM in your community? Please give examples.

B3: Would your community support efforts to improve MHM for girls? What types of effort would the community support? Please explain your answer.

B4: On a scale of 1-9 (with 1 being very low and 9 being very high) what is your view of your community's attitudes towards improving MHM for girls?

Dimension C: Community Efforts to improve MHM

C1: Are there any efforts being made or being planned by your community to improve MHM for girls? If so please give examples.

C2: If so, how long have these efforts been going on and who are they aimed at? Give examples.

C3: Are efforts routinely evaluated and the results used to make changes and improve the activity/intervention? Give examples.

C4: On a scale of 1-9 (with 1 being very low and 9 being very high) what is your view of your community's efforts towards improving MHM for girls?

Dimension D: Community Knowledge of the Efforts to improve MHM

D1: Does the community know of any efforts aimed at improving MHM and how effective they are? If so please give examples.

D2: Are there any sections of your community that know a little (or a lot) about efforts in improve MHM? If so please give examples.

D3: Who (what organisation) do members of the community go to get information about MHM? Please give examples.

D4: On a scale of 1-9 (with 1 being very low and 9 being very high) what is your view of your community's knowledge of the efforts towards improving MHM for girls?

Dimension E: Community Leader's and Influential People's attitudes to improving MHM

E1: Who are the leaders and influential people in your community that have a view on MHM? What are their views on MHM? Give examples.

E2: How are these leaders and influential people involved in efforts to improve MHM? Please explain how they are involved e.g. on a committee, working with an NGO, campaigning etc.

E3: How committed are these leaders and influential people to improving MHM in your community? Give examples.

E4: On a scale of 1-9 (with 1 being very low and 9 being very high) what is your view of your community leader's and influential people's attitudes towards improving MHM for girls?

Dimension F: Community Resources Available to Support Efforts to improve MHM

F1: Do activities to improve MHM have a broad base of support within the community? Please give examples.

F2: How are current community interventions/activities funded and resourced? How is resourcing secured and from whom? Please give specific examples.

F3: Do community activities/interventions have a broad base of community volunteers working with them? Why? Give examples.

F4: On a scale of 1-9 (with 1 being very low and 9 being very high) what is your view of the community resources available to support improved MHM for girls?

Resource 4: Community Readiness to Improve MHM: Scoring Form for Individual Focus Groups/Interviews

Name of Scorer:	
Date of scoring:	
Community name:	
Focus group being scored:	

Please write the appropriate score for each dimension using the Reference Table on pages 6-8:

Dimension	Score out of 9
A: Community Knowledge of MHM	
B: Community Belief Systems and Attitudes Towards MHM	
C: Community Efforts to Improve MHM	
D: Community knowledge of efforts to improve MHM	
E: Community Leaders' and influential people's attitudes to improving MHM	
F: Community Resources available to support efforts to improve MHM.	
TOTAL: *(add all the scores together)*	

TOTAL divided by 6: [ ]

Community readiness to change score for focus group/interview

Resource 5: Total Community Readiness to Change Scoring Form for ONE COMMUNITY

Name of Scorer:	
Date of scoring:	
Community name:	

Name of Focus Group/Interview	Score Given
TOTAL (add all the scores together):	

TOTAL DIVIDED BY THE NUMBER OF FOCUS GROUPS/INTERVIEWS:	

Community readiness to change score for this community