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Social Mobilization

A Process Model based on UNICEF's Experience

Jack C. S. Ling and Anthony Hewett

Social mobilization, as defined by the United Nations Children's Fund (UNICEF), is a broad scale movement to engage large numbers of people in action for achieving a specific development goal through self-reliant efforts. It is a planned process that seeks to facilitate change and development. It takes into account the felt needs of the people, embraces the critical principle of community involvement, and seeks to empower individuals for action.

Following the urgent call for accelerated action by the 1990 Summit for Children, there is a need to move from disparate activities into an integrated process for efforts in child survival, protection and development. Social mobilization answers that need. This paper describes the various elements of social mobilization, details some of UNICEF's experiences, and recommends a model for communication strategic planning.

1. Evolution of UNICEF's Communication Policy

UNICEF began as an emergency organization in the aftermath of World War II to help children in war-torn countries. During its initial phase of operation, it provided food and medications to millions of needy children and mothers and played a much appreciated humanitarian role in the rehabilitation of many prosperous industrialized nations in Europe and Japan.

UNICEF's Scope in the 50's and 60's

In the early 1950's, UNICEF began to turn its attention to the urgent needs of children in the developing countries in Asia, Africa, the Middle East and the Americas. Through the 50's and 60's, UNICEF, in close partnership with the World Health Organization (WHO), provided assistance to developing countries for programs against communicable diseases such as malaria, tuberculosis, trachoma, and leprosy, and for programs that fight malnutrition among children; UNICEF also worked with governments in strengthening health infrastructure for maternal and child care and in expanding primary education.

As an agency operating entirely on voluntary contributions, UNICEF had been active in communication--to generate public interest in the plight of children in the developing countries and to raise funds for its programs. In the 1960's, however, recognizing the role of communication in the development process itself, UNICEF's Asia Regional Office began to turn its attention to communication input to stimulate and improve people's participation in various UNICEF-assisted projects. Initially, such input was labelled as "program-support information"; the term subsequently became project-support communication (PSC) to avoid confusion with institutional public information. Towards the end of the 1960's, a small development communication unit was established by UNICEF, in cooperation with the United Nations Development Program (UNDP), in Bangkok, Thailand.

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Development Communication in the 70's

In the early 1970's, PSC emerged as a recognized term in UNICEF documents, though the appreciation of its specific role in various programs was very inconsistent. By the mid-1970's, UNICEF's Executive Board reviewed and adopted the organization's overall information policy, which included a special section on PSC.(1) By late 1970's, PSC officers were posted not only in regional offices, but also in some country offices, and communication became a regular element in a growing number of country programs.

The 1979 International Year of the Child (IYC), which was promoted and administered by UNICEF, provided an extra impetus in advocacy work for children. Attention on the role of communication in changing policies in favor of children increased substantially. The Primary Health Care (PHC) movement, a joint venture of WHO and UNICEF, which was officially launched in Alma Ata in 1978, was also predicated on the need to mobilize various societal forces for health; it too focussed attention on communication and its role in educating the public about health.(2)

UNICEF in the 80's

The range of UNICEF's communication activities at the beginning of 1980's covered public information and education efforts in the industrialized countries and PSC activities in the developing countries. Stimulated by IYC, UNICEF offices both at the regional and country levels began to clamor for more focussed communication activities to advocate for policy changes at the country level and to mobilize national resources.

Indeed, for a number of years, the question of priority between communication activities oriented toward fund-raising in the industrialized countries, and communication work or PSC, for program implementation in the developing countries, polarized some segments of UNICEF's worldwide staff. Personnel and budgetary requirements began to complicate the demarcation of responsibilities and the use of funds.

Child Survival Initiative

The appointment of James Grant as Executive Director of UNICEF in 1980, however, considerably altered the context for UNICEF's communication work. An advocate extraordinaire and a veteran development specialist, Grant packaged a number of inexpensive interventions under the umbrella of PHC and launched the worldwide child survival and development initiative soon after he took over the reins at UNICEF. Initially these interventions included: growth monitoring, oral rehydration, breast feeding and immunization.(3) Subsequently, other elements such as food security, family planning and female education were added.

Spearheading the child survival initiative is the Universal childhood Immunization (UCI) campaign through the expanded program of immunization, another joint venture of UNICEF/WHO in supporting developing countries to reduce child mortality and morbidity. In order to achieve the broad coverage of UCI, UNICEF stepped up its communication activities both at the policy level through advocacy efforts and at the community level by means of popular involvement. UCI campaigns adopted the successful advocacy lessons of the green revolution in agriculture in the 60's; broadened the mechanism of special events developed by UNICEF's fund raisers; and delved into the process of grassroots involvement which health education has championed.

"Going to (National) Scale"

Going beyond the scope of a particular project, UCI aimed at national coverage. Thus "going to (national) scale" became an approach embraced by

many UNICEF field offices. The strategy which was adopted for achieving a common goal was to encompass multiple types of communication activities covering a broad spectrum of target audiences and objectives. As a result, a framework emerged in which various societal forces are mobilized for a common goal.(4)

And UNICEF calls this broad development strategy: social mobilization.

II. Social Mobilization

Mobilization is a term often associated with war efforts. Animated as it may be by the fervor of a war campaign, social mobilization, as defined by UNICEF, is a planned process that seeks to facilitate change and development.(5) Although it may be perceived by some as being a top-down approach to development, it takes into account the felt needs of the society, embraces the critical principle of community involvement, and seeks to empower individuals for action.

Social mobilization is a broad scale movement to engage large numbers of people in action for achieving a specific development goal, or a series of goals, through self-reliant efforts. It involves different segments of people: decision and policy makers, opinion leaders, government departments, service providers, communities and individuals. It aims at getting political commitment to fully support the implementation of programs designed to bring about these development goals. If the goals involve innovations or new practices, people are empowered to adopt the innovations or practices and to demand supporting technical services. If the goals include behavioral changes, the community and individuals are involved in deciding on the approaches and solutions to bring about the necessary changes.

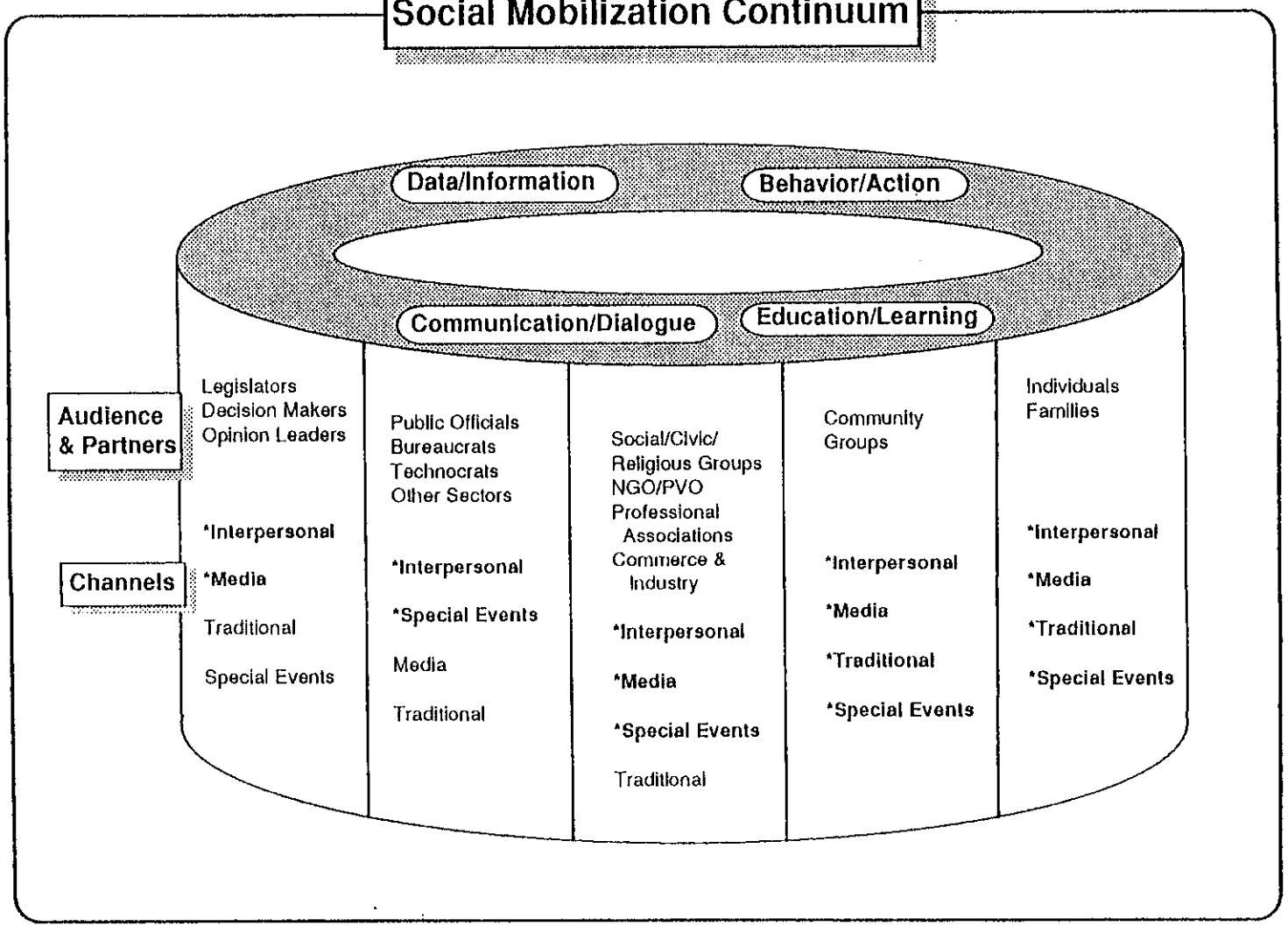
Social mobilization works to create a series of actions that will enable national governments and development agencies to move their work beyond the "project phase" to a national scale. It seeks to create the political will in support of a given development goal and translate that will into viable policies and actions aimed toward meeting that goal. Mobilizing the necessary resources, disseminating information tailored to targeted audiences, and generating the needed intersectoral support are also part of the social mobilization process. Moreover, social mobilization fosters professional solidarity and cohesion, galvanizes popular support, forms alliances and coalitions among related action groups, involves communities, and enables individuals to make informed choices.

A Multi-Pronged Approach

The social mobilization process encompasses communication activities that cover a wide spectrum of societal elements. At the policy level, the outcomes should be a supportive framework for decision making and resource allocation to empower communities for action; at the grassroots level, the outcomes should be people's active participation in achieving the stated development objective.

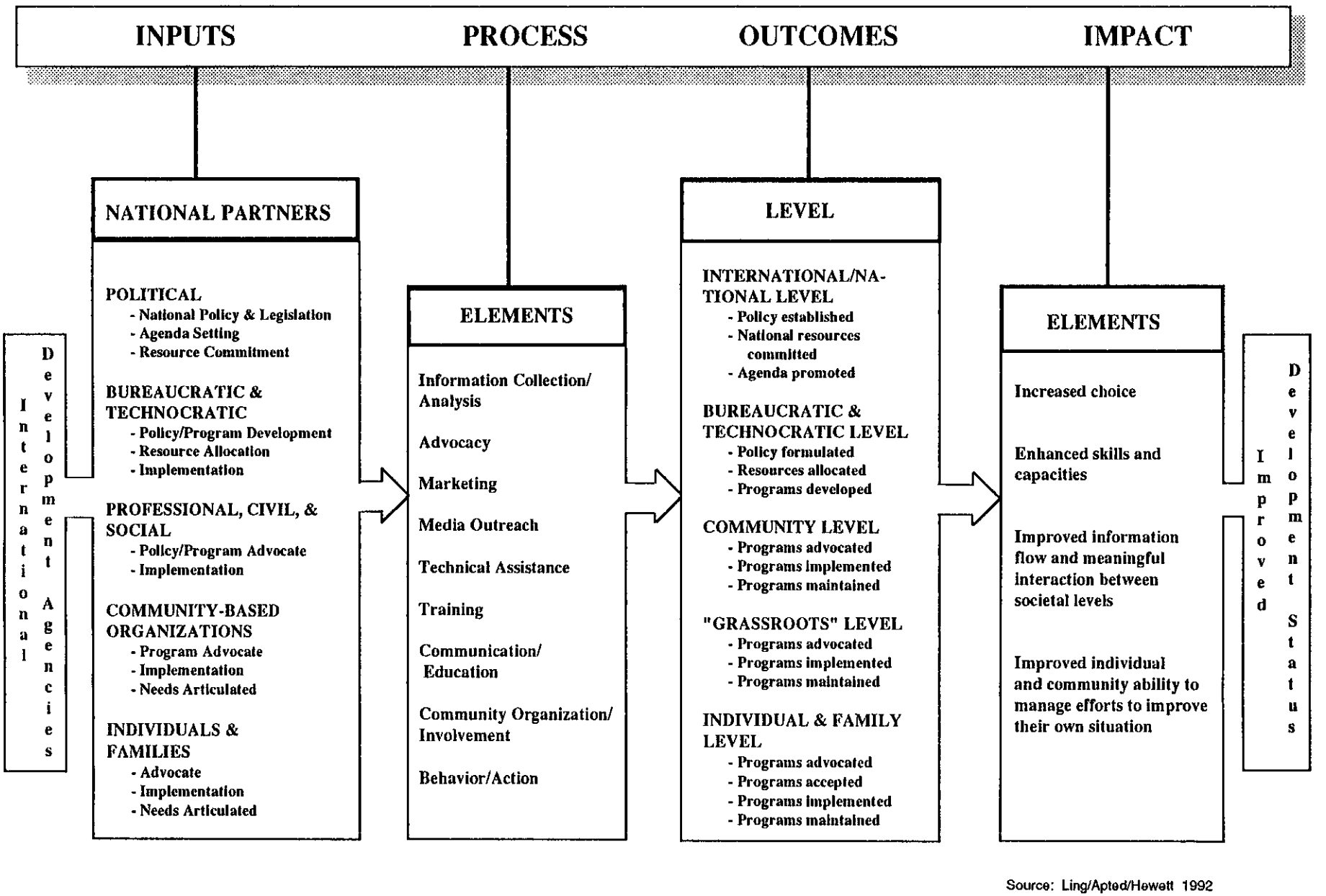
Simply put, social mobilization aims at transforming development goals into societal movements. As Dr. Nyi Nyi, UNICEF's Director of Programs, describes it, social mobilization takes place, " when all social groups aspire to the attainment of a national objective which transcends narrow political barriers, means are found, solutions are developed, and innovations become commonplace." social mobilization is achieved, through the internalization of program objectives by the people, thus ensuring the creation of consumer demand, availability of human, material and financial resources, and multisectoral inputs.(6)

Figure 1: Conceptual Framework
Social Mobilization Continuum



Source: Ling/Apted 1992

Figure 2: Strategic Elements for Social Mobilization



Source: Ling/Apted/Hewett 1992

Conceptual Framework

Given the complex nature of change, an umbrella approach which recognizes the value of a continuum of activities in which each element affects and is affected by the others is adopted.(7) Such an integrated approach allows for greater synergistic impact and should offer a better chance of success in facilitating change.

The conceptual framework for the continuum is illustrated in Figure 1. At the top, the circle shows information/data communicated to various audiences and leads to learning and education, which in turn facilitates behavioral action. The general audience categories shown are only illustrative and represent potential partners for specific action. The categories can be subdivided into different segments and more categories can be added, as circumstances may warrant.

The extreme left column includes the policy markers, who depend on the technocrats, bureaucrats and service professionals shown in the second column to provide the rationale for decisions as well as to plan and implement programs. The center column covers various social institutions and associations who represent organized support,a critical ingredient for common action. The communities shown in the next column are where program implementation and popular participation take place; when communities are involved and necessary skills acquired, people are facilitated to make informed choices.

The channels of communication are also illustrative. Depending on the issues and circumstances, once an assessment of the needs of the segmented audience is made, a judicious mix of media can be chosen to reach the target audience. In some instances, interpersonal channels and face-to-face interactions are emphasized, while in others, mass media constitute the primary channels of communication. At times, special events and traditional methods of communication are sometimes more effective than mass media in generating interest among certain audiences for specific purposes.(8)

Strategic Planning

Each step in the social mobilization strategy includes some or all of the following:

* data collection, research, analysis
* strategic planning, program design, implementation
* logistic support, financial management
* monitoring and evaluation
* segmentation of audience, media campaign
* message design, pretesting, production, distribution
* presentation of information and data
* networking with formal and nonformal education channels
* consensus building, participation of private sector
* involvement of audiences or communities

The nongovernmental sector in particular plays an increasingly important role in development. It includes religious and other social institutions, grassroots action groups, as well as industry and commerce.

The inputs, process and outcomes for social mobilization are indicated in Figure 2, "Strategic Elements of Social Mobilization."The development agencies at the extreme left support national partners in the social mobilization process, which includes a number of illustrative elements. At right are the outcomes expected at various levels, with the improved development status at extreme right.(9)

III. Child Survival: UCI Case Studies

In the early 1980's, of all the Child Survival interventions, immunization was the most urgent and had the greatest potential of saving lives and reducing debilitating diseases. Vaccines against the six major communicable diseases--tuberculosis, diphtheria, whooping cough, tetanus, polio, and measles--had been available for many years. Advances in transportation and simple cold-chain technology had made possible the extension of immunization coverage to the most remote areas. The cost of immunizing a child was between $10 and $15.

Yet, these preventable diseases continue to kill millions of children annually while maiming and incapacitating millions more. the know-how is there to tackle the job, if only the political will was present. The argument for mobilizing for UCI is compelling. as a result, UNICEF began its social mobilization efforts in immunization mid 1980's.

A majority of the developing countries where UNICEF operates has since taken up the UCI campaign. The result has been stunning. from an immunization coverage of 20 % a decade ago, UCI through the expanded program of immunization jointly sponsored by UNICEF and who, has brought the coverage up to 80 %. Statistically, it is estimated that more than three million children's lives are saved annually, and more millions spared from crippling disabilities. The UCI case studies are briefly discussed below.

1. COLOMBIA (10)

Before the Expanded Program of Immunization (EPI) was established in Colombia in 1979, vaccination services were provided irregularly, primarily to control epidemics. In the course of a decade, however, national immunization coverage increased from 20 % to 80 % by 1989. As a result, vaccine-preventable diseases have become uncommon, though significant regional variations persist.

A variety of mobilization techniques were used in Colombia's immunization effort:

a. Political Commitment

A comprehensive national policy and strategy was developed, which was both technically sound and operationally feasible. The support of this policy spanned two successive governments. In addition to presidential decrees and church edicts, President Belisario Betancourt participated personally in the immunization campaigns. Equally important, political and religious leaders at the department, municipal and village levels also took part in the campaigns.

b. A Broad Alliance of Partners

Formation of an alliance of partner institutions in various development sectors, i.e. education, agriculture, social welfare, defense, mass media, etc. was very much part of the immunization strategy. Education provided 350,000 health monitors (high school students given short training in immunization monitoring), military units furnished logistic support, police maintained order, etc. Mass media created widespread awareness of the need for immunization, put it on the public's agenda, helped create a sense of excitement for popular participation during the launching period, and even monitored progress as the campaign unfolded. The Red Cross and other national nongovernmental groups such as the boy scouts and service organizations such as the Rotary Clubs all played an active part in the national program.

c. National Vaccination Days (NVD)

The establishment of NVDs provided a focus for high media visibility and maintained the motivation of partners, i.e. community organizations and grassroots groups. Intensive and extensive media coverage put the issue on the public's agenda and generated enthusiasm among health workers.

d. Community Involvement

The involvement of communities through participation committees at local health posts and incorporating community organizations in the common effort was critical in mobilizing grassroots support. Some 50,000 community based day-care centers trained mothers and entrusted them with the task of seeing that children under their supervision were immunized.

e. Decentralizing operations

Operational responsibilities were decentralized and workers at various field levels were allowed to adapt messages to local realities. This, in turn, facilitated front line workers to undertake critical, interpersonal follow-up to the media information campaigns.

f. Complementary Strategies

The adoption of complementary vaccination strategies provided continuity and broadened coverage. The Ministry of Health's earlier channelling strategy which involved community leaders going from house to house to identify those children not yet vaccinated was supplemented by the intensive annual NVD campaigns. Then, the strategy of "mop-up" home visits was deployed by health personnel to round up those children who had been missed during the campaign and to vaccinate them on the spot.

The program's success was given credit for having fostered a "culture of immunization" among the populace, overcoming parental resistance to vaccination through permanent and sustained education and mobilization efforts. In addition, the UCI experiences in Colombia yielded dividends for the health sector as a whole. New legislation to institutionalize administrative decentralization was enacted. The establishment of Community Participation Committees under the aegis of the Ministry of Health became law in 1990. preventive public health measures now receive much greater attention than before. UCI demonstrated that the strategy to foster an intersectoral alliance for development was possible and can be applied to other development goals.

The Colombian experience, however, showed that mass media efforts can overshadow the critical need to strengthen mobilization structures and processes at the community level. Any over use of media may create a media fatigue syndrome that, if ignored, can be counterproductive. Efforts are necessary to strengthen a decentralized health infrastructure to meet the demand for services stimulated by mass media mobilization. Community education to foster participation and self-reliance should clearly be an integral part of any social mobilization effort.(11)

2. SENEGAL (11)

a. Mobilizing Political Will

In 1985, less than 20 per cent of children under five were vaccinated. The strongest political will was secured in September 1986 when the President of the Republic announced during a visit by the Executive Director of UNICEF, that Senegal would attempt a coverage level of 75

per cent by World Health Day (April 7) 1987. the President's call emphasized that, although immunization efforts were to be coordinated by the Ministry of Health, other ministries--Education, Planning and Cooperation, Social development, Youth and Sports, Communications and Decentralization-- should support the program through a national inter-ministerial committee. Thus, at the policy level intersectoral support was put in place.

b. Mobilization Plan and Implementation Mechanism

The committee moved quickly to see that the logistics of the national program were thought through and the supplies ordered. the necessary training and supervisory arrangements were made as well. Immediately following the presidential declaration, an assessment was undertaken at various levels to identify potential programmatic constraints. A mobilization plan was developed in late October, which called for increased motivation of the health personnel, more strategic use of religious authorities, active participation of village chiefs, trade unions and women movements, a more systematic and decentralized use of the mass media, a more targeted approach in message design, and the establishment of national and regional coordinating bodies. A participatory approach was encouraged in all aspects of program implementation.

c. Mobilizing Social Institutions

The President sent letters to the provincial governors asking them to participate in the program. The governors in turn disseminated the information to their subordinates. Local leaders called meetings or went from door to door to inform people of the importance of immunization and to facilitate their participation. Moslem imams of Senegal's dominant faith responded by speaking about immunization at their Friday sermons, announcing the times and places of the vaccination sessions and in some cases using the minaret loud speakers to inform the public. Imams were interviewed in the vernacular over the national radio programs and some even used their own radio and television time to speak about immunization. The Catholic church's network of health clinics participated as well by delivering the vaccines.

d. Mobilizing the Grassroots

Youth theater groups produced a number of plays, including a compelling drama that addressed the topics of resistance to immunization and the dilemma of traditional versus modern medicine. the Ministry of Youth and Sports informed large groups of people about immunization, with banners, T-shirts and loudspeakers all carrying messages. Popular athletes spoke about the vaccination program and traditional entertainment media such as tam-tam, dances, songs were used to attract attention at sports events and marches. Youth organizations conducted door-to-door canvassing to urge mothers to bring their children to the vaccination centers.

e. Mobilization Through Mass Media

The Ministry of Communications generated extensive radio and television coverage through its national and regional radio stations, which also carried promotional messages for the campaign. the national newspaper, Le Soleil, published 90 articles on the subject. Both a leaflet which included the President's picture and official endorsement, and a poster showing a popular Senegalese singer promoting vaccination proved very effective.

f. 75 % Coverage

Senegal's efforts to increase immunization coverage were unprecedented. Coverage rates for BCG against tuberculosis rose from 33 to 92 %, for DPT/I against diphtheria, pertussis and tetanus from 37 to 81 %, for DPT/3 from 7.6 to 47 %, for measles from 20 to 63 %. As a result, the overall target of 75 % coverage was reached.

g. Sustainability

Unfortunately, the high rate of immunization which resulted from the 1986/87 effort could not be sustained. By the end of 1987, more than half the gain in coverage was wiped out. In 1988-89, a series of mini campaigns employing the same tactics as the earlier program again boosted coverage to about 80 %. However, an assessment made in mid 1989 reported another drop.

The results of both campaigns demonstrated that although social mobilization efforts succeeded to create a strong awareness of immunization, an overall strategy which includes improved efforts to involve the communities is absolutely essential in order to sustain a high coverage rate. Periodic intensive efforts, such as mini campaigns, are necessary to maintain a level of enthusiasm and to keep the immunization coverage at a high level.

3. PAKISTAN (12)

Pakistan has achieved substantial progress since it began accelerated immunization work in 1982. However, Pakistan is a large country with an uneven public health infrastructure among its five provinces, and immunization coverage within the country has varied widely. Punjab, with the largest population, increased its coverage dramatically in just one year, 1984, from 2 to 80 %, and has continued to make progress. Balochistan, the largest province in terms of size, yet sparsely populated, reached only 40 % in 1988 and the figure has since declined.

Though the expansion of outreach services and mobile teams was a key factor contributing to the improvement of coverage, the major media campaign between 1984-86 which informed the public about the availability of services was considered another, equally important factor.

Insufficient Progress

Coverage surveys in 1988 estimated that the national immunization coverage for children under two years of age was 78 %, yet the coverage of children under one was below 40 %. Though progress has been made in all the provinces, the UCI targets have not been reached. Moreover, the progress made so far may not be sustained.

Social mobilization work for UCI, in general, was uneven, and often not well planned and executed. Results were reassuring where the social mobilization concept was broadly applied, as in the case of Punjab. The strategies in Punjab included intersectoral support, involvement of community resources such as traditional birth attendants, addressing the various cultural problems, institutionalizing outreach services with regular budgetary support, addressing lagging motivation with mini-acceleration activities, and recognizing the interplay between mass and interpersonal communication.

Narrow Focus

In spite of the high level of UCI awareness in Sindh, social mobilization efforts within the province suffered from too narrow a focus. Political leaders, nongovernmental organizations and traditional health practitioners

were not involved as much as they should have been. The coverage of fully immunized children under one year of age in Sindh was 20 %, as compared to 46% in Punjab.

The Northwest Frontier made little effort in mobilizing the populace and the general awareness level of UCI was low. In Balochistan, where the health leadership was passive and the use of local mass media for UCI purposes was minimal, immunization coverage levels were the worst in the nation.

Vaccinators Ill-prepared

While considerable media was utilized during the 1984-86 period, no attempt was made to segment the audience nor to tailor the messages to meet their different needs. Considerable uncertainty existed as to how to move from addressing a mass audience to addressing the more individualized needs of families.

The responsibility to carry out face-to-face communication was not clearly defined. In most instances, community workers or the vaccinators, although trained in technical vaccination skills rather than communication were the only ones who were providing messages about vaccination.

More Mobilization Needed

The use of ineffective approaches to social mobilization was clearly a major factor in the lack of sufficient progress in UCI. While service delivery was weak in many areas, there were also reports of vaccine shortages. Clearly, a comprehensive, integrated strategy of social mobilization was called for. Among others, the Pakistan experience recommended the following steps:

a. Reach for a broader alliance that includes political leaders, the private sector, other development sectors, and traditional health personnel who have deep roots in the community.

b. Train health personnel from district health officers to the vaccinators in mobilization work. Civic leaders and village mothers need to be educated about the importance of immunization for their communities.

c. Learn more about the target audiences so that public health personnel know how to communicate with them and to involve them in planning and implementing UCI activities.

d. Integrate mass communication with interpersonal communication drawing upon health workers at the community level.

e. Decentralize communication activities to meet the varying needs of the provinces and the districts within the provinces.

IV. UNICEF's Own Assessment

The campaign approach has proven to be highly effective in raising public awareness and generating immediate action. However, a comprehensive strategy with a judicious mix of campaign tactics and community organization work is clearly needed in order to sustain the durability of the awareness and to maintain the level of achievements. Efforts are needed to transform the gain into a permanent part of health care delivery.(13)

Getting a mother to bring her child to a vaccination post once or twice, without meaningful education about the reasons for immunization, does not ensure a repeat performance in future years. Building infrastructure, putting

service delivery on par with promotion, including health education in school curriculums, and providing continuous support for sustainability are essential. Above all, episodic efforts whether they are for advocacy through mass media or promotion activities at the community level tend to become fireworks that fizzle out in a short span of time and leave no permanent mark.(14)

The UCI objective, although a useful global advocacy theme, may have been perceived as an end in itself rather than as a means of creating or reinforcing the demand side of a sustainable service delivery system. In fact, a sense of dependency on external development agencies may have developed.

Therefore, some of the points which social mobilizers should bear in mind:

1. Develop a comprehensive social mobilization strategy based on a continuum of activities. Activities should include advocacy work at the policy end and community education and involvement at the behavioral end. In between are the critical steps to mobilize support from and develop partnership with various groups at different levels.(15)

2. Pay sufficient attention to planning. There must be adequate research on potential blockages in resource allocation for social mobilization efforts (national or community), perceptions of needs from the point of view of the target population and institutional capacities of those involved in the enterprise.

3. Develop a broader, longer-term strategy that takes into account the sustainability of gains, motivation of personnel (especially at the front line), and a continuing resource support, both financial and personnel.

4. Genuinely collaborate with other sectors from the planning stages through implementation. In other words, encourage a sense of ownership of the effort.

5. Build infrastructure to support new work, including the institutionalization of new initiatives, such as budget lines and categories of activities. Without a proper infrastructure, the momentum of acceleration or the new activity itself invariably loses steam and fades away.

6. Emphasize capacity building at the national, provincial and district levels; decentralized operations that don't build capacity nor have adequate support from the center are doomed to fail.

7. Build a feedback mechanism into the overall plan in order to evaluate activities, phase by phase, and to allow for adjustment.

8. Keep an eye open for new communication technologies, but also draw upon those traditional forms of communication in which people have confidence.

9. Avoid general-formula solutions, as each country, province and district calls for a specific strategy.

10. Learn to compete for attention in the marketplace of ideas. in addition, be prepared to engage in public debate, and to accept the fact that there is rarely a clear cut win or lose situation.All encounters offer an opportunity for advocacy.

V. Training and Research

While there is a wealth of development specialists in a variety of fields, i.e. education, agriculture, health, nutrition, water and sanitation, there are very few, if any, with systematic training in social mobilization. As the momentum to accelerate development efforts builds following the recent Summit for Children , UNICEF and Tulane's School of Public Health and Tropical Medicine have teamed up to develop such a training and research program in social mobilization.(16)

Until now, many promotion and advocacy tasks have been managed by those with journalism and/or public relations background, as they often work with the media. Social marketers have managed the distribution and acceptance of products and services. Health educators have worked with communities to ensure involvement and facilitate participation. Health care providers ranging from physicians to scientists, from nurses to engineers, have tried their hands at various mobilization tasks. Clearly, there is a need for generalists who can manage social mobilization efforts in their entirety, rather than by isolated components. The UNICEF/Tulane program plans to fill that need.

Training Course

The social mobilization strategist should have a broad technical base, with training in advocacy and lobbying, media work and liaison, policy and management, social change theories, training and learning principles, and public health practices and community development. Such a specialist would need an appropriate combination of programming/managerial skills, conceptualizing and organizing abilities, quantitative and qualitative analytic capacities, as well as communication/education competencies.(16)

A training course would need to include topics covering such areas as theory and practice of social structural change, behavior modification, the intersectoral nature of effective development, linkages between economic and social factors and quality of life issues, program planning and implementation, human resource development and information systems.(17)

In addition, training in basic quantitative analysis and epidemiology fundamentals are needed. Some understanding of operations research and its role in program development would be relevant, as would understanding of the role of monitoring and evaluation in program management. Vital communication/education competencies would include campaign development and advocacy skills grounded in appropriate theoretical and practical frameworks, audience/user analysis and segmentation, message selection and design and media strategies. Also essential would be some understanding of community development and participation processes.

The role of development agencies, such as UNICEF, in social mobilization is to support and assist national efforts in mobilizing partners and forming alliances. The eventual goal is an improvement of the status of development.

Operations Research

In order to overcome obstacles in the social mobilization process itself, operations research is critical. Program managers and service providers are often hard-pressed by implementation details to devote time to such research. Institutions of higher learning in developing countries can play a key role in social mobilization research.

Relatively few research efforts have been undertaken to look at how individual project achievements can be translated into national program success. Technical areas such as water and sanitation, or nutrition, as well as

management problems, such as intersectoral collaboration are potential issues for operations research. The research agenda will mostly likely be shaped by program managers working in conjunction with universities with research capacity in social development.(18)

Globalized Program Through Linkages

The training research program will be globalized through complementary activities with selected developing country partners. Through careful design, the globalized program will retain significant regional and national relevance. Close involvement of other developing country institutions will help to strengthen the sustainability of training and research in countries where health needs are the greatest.(19)

Once the prototype training program has been developed, efforts will be made to link together a number of institutions in various regions of the developing world for faculty exchange, joint curriculum development, training activities and research. Such linkages are essential for building the necessary capacity within developing countries for social mobilization training and research.

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