THINKING CREATIVELY

WHAT **FIMR** TEAM MEMBERS NEED TO KNOW TO FOSTER **COMMUNITY BUY-IN**

Elizabeth G. Serow, PhD, MPH • *Office of Policy, Education and Data Analysis* • *Florida State Deparment of Health* • Tallahassee, FL

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The National Fetal and Infant Mortality Review (NFIMR) Program is a collaborative effort between the American College of Obstetricians and Gynecologists and the Maternal and Child Health Bureau, Health Resources and Services Administration Grant #U08MC00136

June 2005

Introduction

This document adapts very important concepts that underpin the development of community support for the FIMR methodology. These adaptations provide important insights that will help FIMR team members foster community buy-in for taking recommendations to action. First, this document discusses how the ideas from the Assets-Based Community Development (ABCD) initiative can be used to mobilize the resources of the community from within to support FIMR actions that can improve community health and well being. Second, it amends Maslow's Hierarchy of Needs to include health care issues and makes plain that much more basic needs for food, shelter and safety most be met before an individual or a community can focus on health priorities. For new FIMR teams, having a thorough understanding of both concepts is key to bringing about diverse community buy-in and successful community action. (1) (For information on the ABCD Institute, see the ABCD Bibliography at the end this bulletin. For more information about Abraham Maslow, see Maslow A. Motivation and Personality, 2nd ed., Harper & Row, 1970.)▼

FIMR in a Nutshell

FIMR is a community coalition that brings together a broad range of ethnic and cultural views in the community. Experienced FIMR programs say that such diversity is the best way to ensure that all sides of an issue are identified and addressed. In turn, this sharing of diverse community values provides a framework for the team to become more aware of community cultural requirements. (2)

Successful FIMR programs include a wide variety of culturally diverse partners in their activities. Typically FIMR engages 30 - 50 active community members to work together including providers, policymakers, representatives of organizations and agencies, families and consumer advocacy groups. Team membership should reflect both the community at large and the community most affected by high infant mortality rates. (2) (See Worksheet 1: Community Participation: A FIMR Member Checklist on next page)

Successful Fetal and Infant Mortality Review (FIMR) programs frequently have a two-tiered culturally diverse teams system: the case

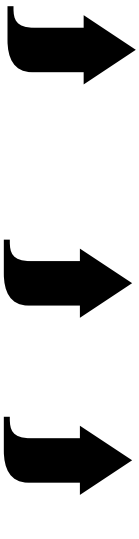
The FIMR Process is Action-Oriented

The Process

CASE REVIEW TEAM
Reviews cases, identifies gaps in service systems and resources and reports to

COMMUNITY ACTION TEAM
Assesses broader issues, translates issues into interventions and reports to the

COMMUNITY



Creating Solutions Where None Exist:

- Within Provider Groups and Organizations
- Between Providers and Organizations
- Across the Community

Adapted from: South Carolina FIMR

Worksheet 1: Community Participation: A FIMR Member Checklist

PLEASE INDICATE THE NAME OF THE PERSON WHO CAN PARTICIPATE IN THE FIMR PROCESS

Reminder: Some community members will participate on the Case Review Team or on policy development through the Community Action Team. Everyone benefits form improved collaboration.

Key Community Leaders

- ❑ Mayor, County Executive: _____
- ❑ Religious Leaders: _____
- ❑ Business Leaders, Chamber of Commerce: _____
- ❑ Civic and Fraternal Groups, such as Kiwanis, Jaycees, AKA, Junior League, etc.: _____
- ❑ Educators: _____
- ❑ Others: _____

Health Care Providers

- ❑ Obstetrician/Gynecologist: _____
- ❑ Pediatrician/Maternal–Fetal Specialist: _____
- ❑ Obstetric/Pediatric Nurse: _____
- ❑ Social Workers: _____
- ❑ State and/or County Medical Society: _____
- ❑ Hospital Administrator: _____
- ❑ MCO/HMO Representative: _____
- ❑ EMS: _____
- ❑ Others: _____

Public Health Providers

- ❑ City and/or County Health Department(s): _____
- ❑ Medicaid: _____
- ❑ Medical Examiner: _____
- ❑ WIC Supervisor: _____
- ❑ Outreach Workers: _____
- ❑ Family Planning Representatives: _____
- ❑ Others: _____

Human Service Providers

- ❑ Child Welfare Agencies: _____
- ❑ Substance Abuse Services: _____
- ❑ Mental Health Services: _____
- ❑ Department of Corrections: _____
- ❑ Housing Authority: _____
- ❑ Transportation Authority: _____
- ❑ Other: _____

Consumer and Advocacy Groups

- ❑ March of Dimes: _____
- ❑ Healthy Mothers/Healthy Babies: _____
- ❑ MCH Coalitions: _____
- ❑ Perinatal Infant Grief Professionals: _____
- ❑ Bereaved Family and Other Consumer Representatives: _____

Consumer and Advocacy Groups

- o Family Support Groups (SIDS) Alliance, Compassionate Friends, etc.): _____
- o Minority Rights Groups: _____
- o Women's Rights Groups: _____
- o Union and Workers Rights Groups: _____
- o Housing and Tenants Rights Groups: _____
- o Others: _____

Adapted from: Striffler N, Coughlin, PA, Magrab, PR. Communities can workbook series: developing collaborative services for children. Washington, DC: Georgetown University Child Development Center. 1994:4 and Phelps, A. Florida Department of Health

review team (CRT) and the community action team (CAT). (3) Members of the CRT represent a broad range of professional organizations, public and private agencies (health, welfare, education) that are currently providing services and resources for women, infants, and families, as well as community advocacy groups. As the CRT examines each case, the team should ask the following questions:

- Did the family receive the services or community resources they needed?
- Were the systems and services culturally and linguistically appropriate?
- Are there gaps in the system?
- What can this case tell us about how families are able to access the existing local resources?

The CRT may identify barriers to care and trends in service delivery and suggest ideas to improve policies that affect families.

Typically, recommendations from the CRT are presented to the CAT. The CAT is composed of two types of members: those with the political will and fiscal resources to create system change and those community leaders and consumers who can define a perspective on how best to create the desired change in the community. Both viewpoints are important. The CAT translates the CRT recommendations into action and participates in implementing interventions designed to address the identified problems. ▼

Beginning Programs from the Inside Out —Evolution of the ABCD Process

Two of the most notable experts advancing the message of building communities from the inside out are John Kretzmann and John McKnight of the Institute for Policy Research at Northwestern University.

Under the rubric of Assets Based Community Development (ABCD) they have been working since the late 1960s to help communities and community helpers address problems such as violence, health care, education, housing, and drugs—the typical issues that negatively affect a community and make it difficult for its members to lead physically and mentally healthy lives. (4) (For information on the ABCD Institute, see the ABCD Bibliography at the end this bulletin.)

Their message is twofold. First, they say that helpers from the outside will never be able to bring about change without the consent and support of those on the inside. Second, they assert that change will never be lasting unless it is brought about by those on the inside who become empowered in the process to take on other issues affecting their lives. ▼

ABCD in a Nutshell

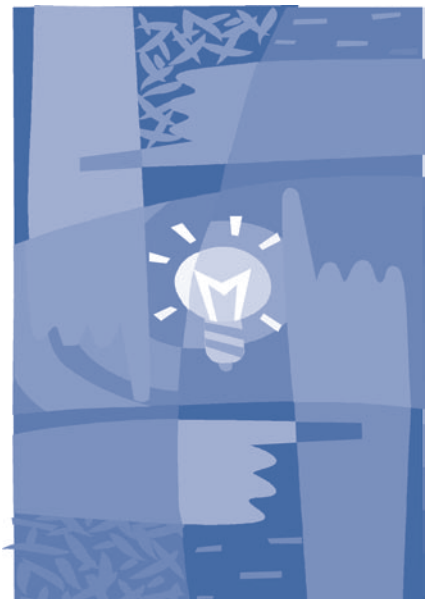
Simply put, ABCD is an approach to community development based on making a paradigm switch from a negative one of *documenting needs* to a positive one of *discovering assets*. This switch involves identifying assets of public and private institutions, community associations, and individuals and then working to strengthen partnerships among all of those asset-holders to get things done.

The three basic steps of ABCD, as explained by Kretzmann and McKnight, can be incorporated into the FIMR process and are as follows: (5)

- Start by identifying assets of a target area, not solely elaborating on the needs.

  In the traditional way of approaching community change, most public health planners think first of developing a *needs map* or *needs assessment*. Most local and state public and private grants request this information up front, so programs such as FIMR may spend a

great deal of time expounding on all the things wrong with the area in which they hope to work. To do so, many FIMR programs begin by building a needs assessment (See Illustration 1 on page 10). The assessment may include statistics on infant mortality, low birth weight, neonatal and post-neonatal mortality, the incidence of birth defects, the percentage of broken families, substandard housing, the literacy rate, school drop out rates, and all the other things that make the community area appear deprived.



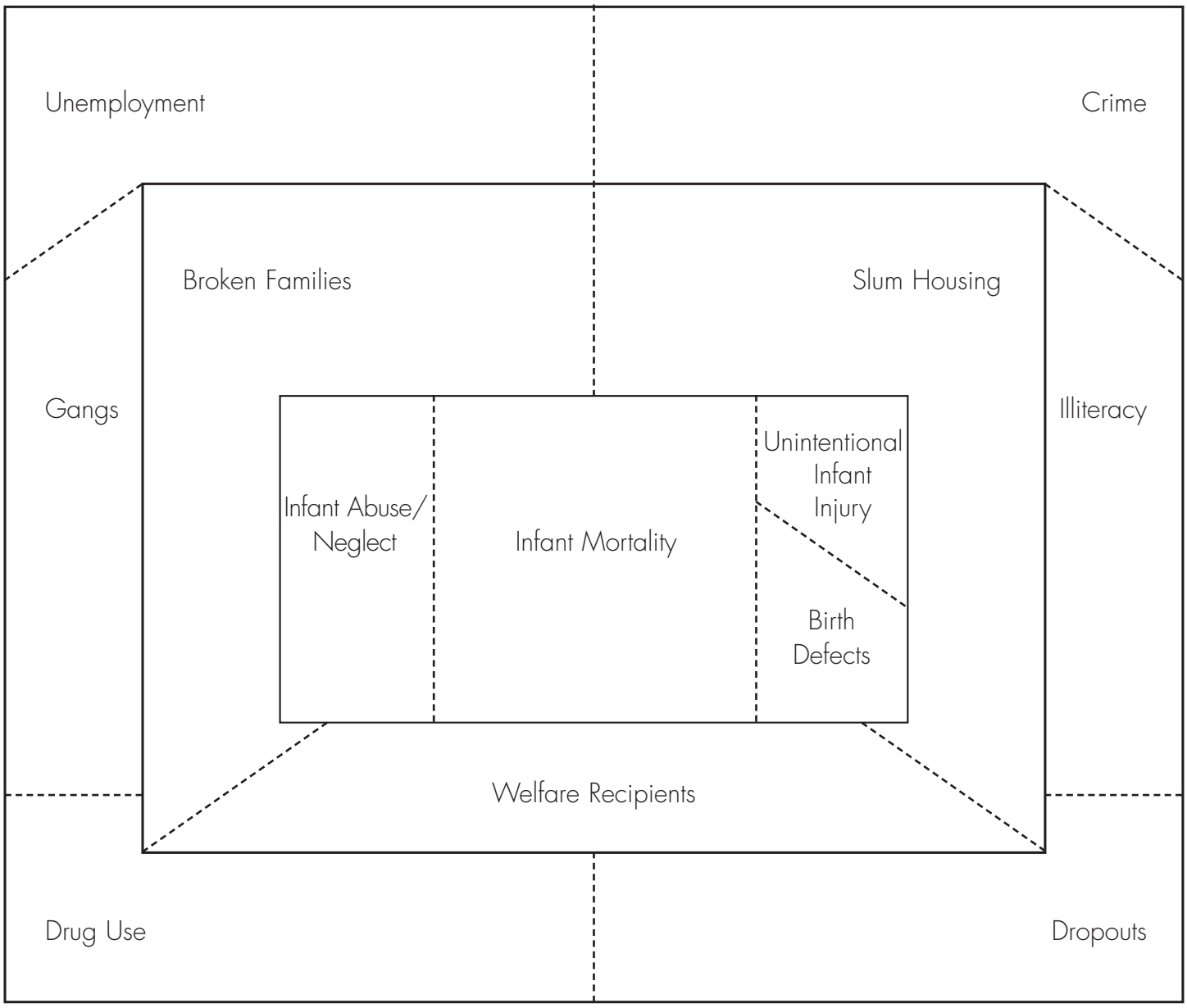
Many health planners, including FIMR sponsors begin by preparing these reports because that is what they have been trained to do, but in addition to overlooking the assets of a community, the traditional needs assessment process has a basic disadvantage. Focusing on the negative data and on the needs of a community commits a program to measuring outcomes in terms of reducing the needs. The philosophy is that the community is always "a glass half empty, never a glass half full."

In contrast, Kretzmann and McKnight support an approach that uses existing information to identify the assets of an area, as well as its needs. They then suggest determining how to tap those assets. An *assets assessment or map* (See Illustration 2 on page 11) can help the FIMR process too. Once this crucial psychological and methodological shift from a needs focus to an assets focus has begun, the time has come to begin the second step of the ABCD process.

- Identify and engage two community building blocks: institutions and associations.

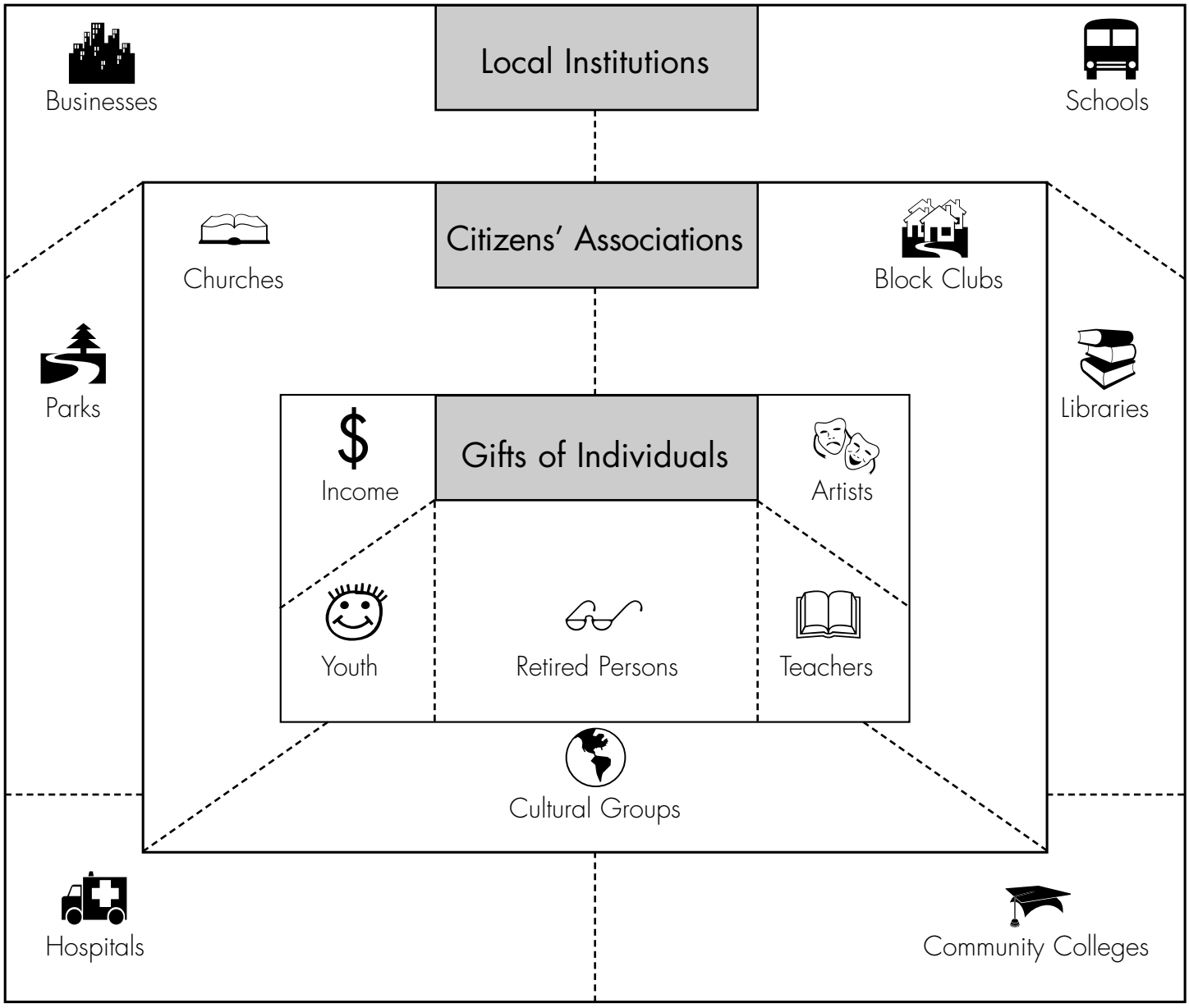
The first group of community assets includes its institutions. Institutions usually submit typical maternal and child health grant

Illustration 1: Neighborhood Needs Map



Adopted with permission from: Kretzmann JP, McKnight JL. Building Communities from the inside out: a path towards finding and mobilizing a community's assets. Chicago, IL. Institute for Policy Research, Northwestern University, 1993.

Illustration 2: Community Assets Map



Adopted with permission from: Kretzmann JP, McKnight JL. Building Communities from the inside out: a path towards finding and mobilizing a community's assets. Chicago, IL. Institute for Policy Research, Northwestern University, 1993.

proposals. So when Kretzmann and McKnight talk about public and private institutions, they mean health departments, hospitals, social service agencies, etc.

Kretzmann and McKnight, however, also challenge those interested in building stronger communities to identify citizens' associations with which they can work. The distinction between associations and institutions is that the former are groups of individuals who freely choose to join together to get something done for a common cause. There are legions of associations, including organizations like the Sierra Club, neighborhood block associations, church missionary societies, women's clubs, senior clubs, and gardening clubs. People in these organizations get together around an issue, something recreational, or anything at all that draws them together, not because they are paid to be there but because they have a common interest. The time and energy that people put into associations is there to be tapped.

The easiest way to identify associations in a community is to brainstorm lists by looking at community resource directories, referral directories and the phone book, and by tapping the expertise of the residents. Most often, the initial list is surprisingly long. The American Association of Pediatrics has an excellent resource titled *New Community Tools for Improving Child Health: A Pediatrician's Guide to Local Associations* (http://www.aap.org/visit/cbita.htm).

An initial FIMR program assets list of associations might include day care collaboratives, college associations, a mental health group, service clubs, fraternal organizations, scouting groups, voluntary health associations, faith-based organizations, student associations, and booster clubs, in addition to all of the public and private institutions that serve

children and families, such as schools, colleges, child welfare, health departments, etc. The most successful FIMR programs start with a long list and then have the leadership that is spearheading the local FIMR effort scan the list to identify potential partnerships that might work to mutual advantage.

Most agencies and organizations have not looked for positive community assets to mine for help. However, there are built-in incentives for FIMR to develop multiple community partnerships. As Kretzmann and McKnight say community change must occur from the inside out and every community has valuable assets that can make change happen. For example, in one FIMR community:

- The local high school provides meeting space for prenatal smoking cessation self-help groups
- The Healthy Start Coalition provides paper, postage, and copying for distribution of new health education materials
- The March of Dimes provides support for an annual FIMR medical grand rounds
- The local medical society provides space and lunch for FIMR case review team meeting
- The Zeta Phi Beta Sorority provides incentives and encouragement for women to keep prenatal care appointments
- The local mall makes a special effort to encourage pregnant women to take a daily fitness walk in their facility
- Retired nurse volunteers from the American Association of Retired Persons (AARP) visit isolated, rural first-time mothers to teach SIDS risk reduction and give the mothers an opportunity to talk about their parenting concerns

- Retired business men and women teach money management to new families

- The Kiwanis Club provides smoke detectors to families with newborns that request one and will even install them, if needed and

- A local college drama group provides theatrical vignettes at a Community Forum to help illustrate locally significant barriers to receiving comprehensive prenatal care.

Once the institutions and associations who might have a stake in FIMR have been engaged, it is time for the third step in the ABCD process.

- Engage individuals in the community.

In addition to the resources institutions and associations offer a community, an extensive array of talent is available from the individuals who live and work in the community. Artists, teachers, the elderly, tradesmen such as carpenters, plumbers, etc., the handicapped, young people—the list is never-ending. When the FIMR action agenda is ready to be implemented, it is time to identify and tap the contributions of appropriate individuals. Individuals have wealth of resources to help FIMR take recommendations to action.

The best way to find these appropriate individuals is to partner with a group that already has credibility in the community and already meets periodically. When such a community group has already assembled for a meeting, try conducting an assets inventory exercise (see box on next page) at the start. This asset inventory is not only an icebreaker but also a way to convey the message that the resources that already exist will be identified and tapped. Once you identify individuals who can and want to help be prepared to work with them right away.

Think creatively! The FIMR program might find out that their community has many gardeners who would be great resources for a Weed and Seed Program that could contribute to the development of a safe park and playground specifically for infants and toddlers in the neighborhood. People with athletic interests could develop and supervise after-school teen activities and sports programs, which then can become an innovative approach to teen pregnancy prevention. People that love to organize will stand out in the course of the group meeting and can quickly become a valuable part of the community change structure.

Assets Inventory Exercise

- Give group members an assets checklist/inventory sheet as they arrive at the meeting, or have one waiting for them at their seats.
- Ask them to complete it during the first few minutes of the meeting.
- Include questions about such untraditional assets as hobbies, special talents, languages spoken, favorite foods, the clubs or organizations to which they belong, etc. (Answering these questions will help the members of the group be more creative.)
- Ask one person to stand and share what he or she has listed under hobby, and then ask everyone else in the group with the same hobby to stand.
- Keep going until everyone has risen from their seat at least once.

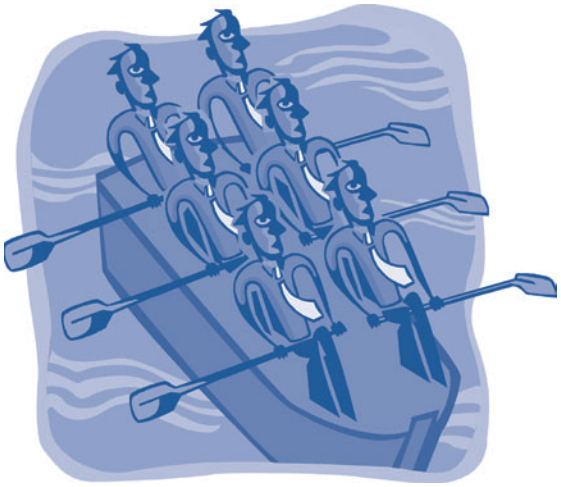
Although these activities are not directly focused on reducing infant mortality, when a FIMR program broadly defines positive community action and taps into the resources that the members bring to the team, the team will be more successful in accomplishing its goals. ▼

Anchoring the CAT in the Community

Every successful FIMR CAT has to have an anchor, a core sponsoring organization that will choose the team members, chair the meetings, and track team action with enthusiam. For FIMR programs, the most common sponsor is the local health department. Other sponsors include hospitals, universities, medical societies as well as perinatal consortia and community coalitions. In addition, many CATs have the same sponsor as the CRT. The CAT, however, does not necessarily have to be anchored in the same sponsor as the CRT. For example, in Aiken, South Carolina, the CRT was anchored in the health department and reported its findings to the CAT, which was anchored in the mayor's office. In Camden, New Jersey, the CRT is anchored in the regional perinatal coordinating council and the CAT is anchored in the Healthy Mothers/Healthy Babies Coalition.

Coalitions that become the sponsor for the CAT have some advantage because they already have a mix of diverse community partners at the table. There are many local coalition groups, such as the federal Healthy Start Coalition, Healthy Mothers/Healthy Babies, perinatal regional councils, and a mayors' or governors' blue ribbon panels on infant mortality, that have been successful CATs. In fact, the NFIMR manual recommends only forming a new separate CAT if no other comparable group in the community exists. The membership would certainly overlap and key members, who would be asked to do much more work than before, would eventually burn out. (6).

Local health departments are frequently the first choice for a CAT sponsor since they are the main initiators of such maternal and child health activities as prenatal care and immunizations. There is an important caveat, however, for health departments that elect to take on this role. Health departments have the tendency to assume that because they have mandates to do things that keep the community healthy, the community has the same mandates. This often leads to expectations that others will share the health department's goals and to frustration and anger when they don't. Because of this potential for misunderstanding, the time spent determining mutually beneficial contributions among the CAT partners is of particular importance when health departments take the lead.



The FIMR program sponsor is typically responsible for identifying a wide range of potential team partners. All team members should be chosen with an eye as to how they can contribute to community change. In fact, almost all team members should have the potential to be community change agents.

Regardless of who is designated as the sponsor of the CAT portion of the FIMR process, there is a place at the table for truly diverse community partners who might not usually be associated with the FIMR CAT. For example, parks/recreation departments, faith communities, educational institutions, libraries, big businesses, small businesses, community-based organizations, tenants' associations, artist schools, or co-ops all can potentially create community change. The FIMR sponsor should take the lead in figuring out what these potential new team members might do for the community and what the FIMR program can do for them.

Small and large businesses are frequently left out of the FIMR planning mix because they don't seem to be directly related to health care. Business people *do* have a stake in the community's health, however,

because when a neighborhood is healthy, businesses will have employable people to draw from, and fewer worries about crime cutting into profits. Furthermore, an unhealthy community could affect their own workers health, thus increasing the businesses' health insurance cost.

Businesses might be willing to give discounts or coupons to women who start prenatal care early, complete 10 visits, or perform some other health-related activity. They may also be able to provide publicity, food or space, since they typically have more flexibility than public institutions. In exchange, the health department might be able to provide health screenings or flu shots for the company's employees.

The easiest way to conceptualize this "give and get" approach is to utilize two Illustrations developed by Kretzmann and McKnight. The first is a wheel matrix where the FIMR sponsor is identified in the center of the wheel and important FIMR partners are identified on the outer rim of the wheel. The actions that the partners can provide to the sponsor organization, and what the FIMR sponsor organization can offer the partners in return, are written on the spokes of the wheel (See Illustration 3 on page 20). (Also See Worksheet 2: Expanding One-On-One Relationships for the FIMR Community Action Team on page 21)

The next task is to identify ways to foster those partnerships. Use the wheel chart to generate a list of organizations and key people on which the FIMR program needs to focus and some of the tasks that need to be done (See Illustration 4 on page 22). These discussions may not fit into routine CAT meetings but taking time once or twice a year to identify and promote new partnerships is crucial to building infrastructure for a sustained FIMR effort rather than a short-term venture.

Everyone in the matrix who contributes resources—time, money or materials—builds the community as a whole while simultaneously accomplishing their own missions. This is because the *underly-*

ing causes of so many of a community's poor outcomes are the same. Thus, almost any activities undertaken to address them—actions that build the capacity of children, young people, and families are likely to achieve many local organizations' and funders' goals.

By understanding the community's broader civic priorities and problems and reframing FIMR issues to fit, FIMR will be able to identify many new strategies that will be supported by funders whose main concern is not infant mortality but drug abuse prevention, school drop out rates, job skills, etc. Families dealing with each of these problems typically live in the same neighborhoods targeted for intervention by FIMR recommendations. Knowledgeable FIMR programs know how to link activities directly related to FIMR findings and recommendations onto activities that existing grants will fund.

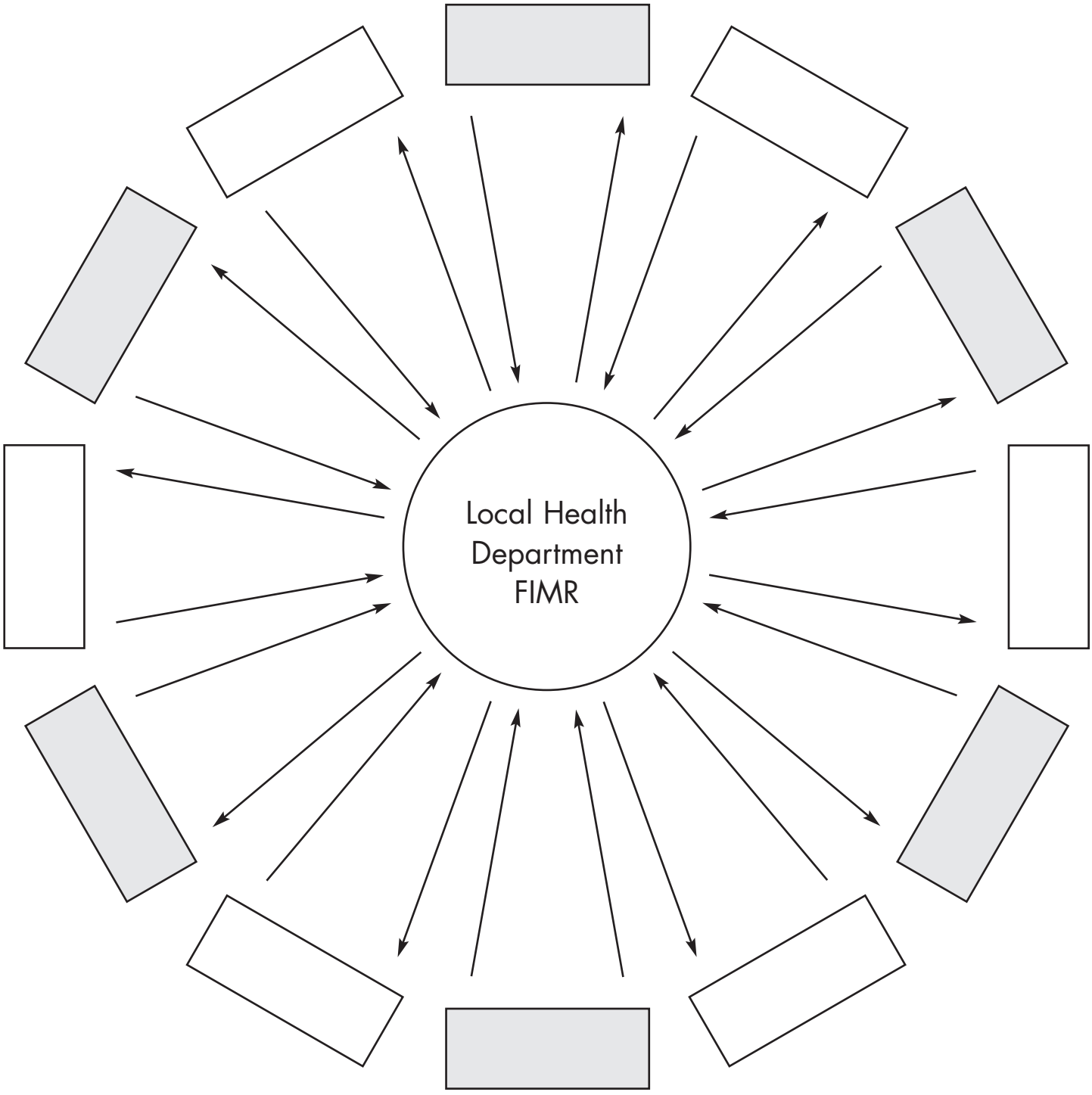
A successful example of this approach comes from a group involved in neighborhood development in a poor section of a Florida community. The school system was concerned that too many children were dropping out of school. The Chamber of Commerce worried because graduates had insufficient job skills. The FIMR program found that teen pregnancy rates and infant mortality rates were also high for girls who dropped out of school. Parents in the community would support anything that helped their children to stay in school and to develop special job skills, such as computer literacy. The only grant funding available at the time, however, was for drug abuse prevention.

So, members of the FIMR CAT wrote a grant for drug abuse prevention education based on a self-paced computer course. The students had to learn how to use the computers proficiently in order to complete the course. Some students were assigned to researching and developing drug

Illustration 3: Additional One-On-One Relationships for Health Department-Based FIMR Community Action Team

Adopted with permission from: Kretzmann JP, McKnight JL. Building Communities from the inside out: a path towards finding and mobilizing a community's assets. Chicago, IL. Institute for Policy Research, Northwestern University, 1993.

Worksheet 2: Expanding One-On-One Relationships for the FIMR Community Action Team



Adopted with permission from: Kretzmann JP, McKnight JL. Building Communities from the inside out: a path towards finding and mobilizing a community's assets. Chicago, IL. Institute for Policy Research, Northwestern University, 1993.

Illustration 4: Expanding the Community Action Team Partnerships

Adopted with permission from: Kretzmann JP, McKnight JL. Building Communities from the inside out: a path towards finding and mobilizing a community's assets. Chicago, IL. Institute for Policy Research, Northwestern University, 1993.

education modules, others had to test them out, and still others used the modules as background for writing exercises. Older students learned how to maintain the equipment. All of the content was drug related, of course, which met the funding requirements and helped meet the funder's goals.

Eventually Graduate Equivalency Degree (GED) and job search programs were made available on these same computers after hours. More teenagers stayed in school, graduated, and got jobs. Fewer teens used drugs. Gradually, the teen pregnancy rate and the infant mortality rate for teens decreased. Teens who had dropped out of school came back to get their GEDs. It was a win–win situation for FIMR and the community in every way.

Another success story comes from a Florida community Healthy Start program. The community faced a real problem with criminal vandalism when middle and high school students were suspended from school. Seemingly unrelated, the FIMR team found during case reviews that the teens who miscarried were often smokers. They also found that several of the teens appeared to have gotten pregnant while suspended from school. Smoking cessation grant funds were available. The FIMR director helped the school system write a proposal to fund a teacher to provide in-school tobacco education programs throughout the day. All students that formerly would have been given out-of-school suspension were assigned instead to sit in on these classes. Thus, an in-school suspension program not only kept teenagers off the streets, it could be used for other things such as educated teens about smoking cessation: a prevention measure for the teens who had miscarried in the community. ▼

The Forgotten Dynamic

The success—and the challenge—of the ABCD method is rooted in the fact that many community members are engaged in the process and that it is "relationship driven." The central responsibility of the community group is "to constantly build and rebuild the relationships between and among local residents, local associations and local institutions." (7)

This concept fits well with the FIMR process. FIMR engages many diverse CRT members to generate recommendations during the case review stage. It calls on a diverse CAT membership to move from recommendations to action.

Because of the diversity, FIMR team members may not always agree on a given course of action and must compromise to move forward for the good of the community.

Building and maintaining positive relationships is an integral part of the FIMR process. In order to succeed, it is to the advantage of the FIMR team leaders to become skilled in understanding group dynamics, resolving group conflict positively, maintaining a democratic structure, and helping constructive compromise to happen. In and of itself, building and maintaining positive relationships within a truly diverse FIMR team is a successful action. Building relationships within truly diverse FIMR teams can also have significant ripple effects on the harmony of the entire community. (See Worksheet 3: Is Your FIMR Program Fostering Local Community Support and Buy-In? on next page) ▼

Worksheet 3: Is Your FIMR Program fostering local community support and buy-in?

FIMR's position in the community is, ideally, one built around strong community partnerships with other organizations and consumers that, thankfully, collaborate to improve services and resources for women, infants and families. FIMR programs, which have received funding and lasted for over a decade or more, all tell us that they have continuously promoted community buy-in and marketed their successful actions to a larger community. In these changing times, the big question for many FIMR programs is, "Does your community know about FIMR and it's successful actions?" To gauge the community's awareness of FIMR and promote community buy-in, take a moment to review the Community Assessment Checklist below:

Community Assessment Checklist

YES NO

___ ___ 1. In the beginning stages of your program, were you able to make adequate time to "lay the foundation" and recruit influential leaders and consumers from key sectors of the community to help plan and build your FIMR program?

___ ___ 2. Does the composition of your team reflect the cultural diversity of your community?

___ ___ 3. Should you recruit additional team members that bring additional leadership, the power to create change and new points of view to the FIMR case review team and community action team?

___ ___ 4. Can your FIMR document a positive impact on local problems? Have many successful actions been implemented as a result of FIMR recommendations?

___ ___ 5. Do you use multiple strategies to promote broad community awareness about FIMR's contribution to improving health and human service systems in the community?

___ ___ 6. Does your mayor or county executive know about the FIMR program and it's successes in taking recommendations to action?

___ ___ 7. Do ordinary people in the larger community know what F-I-M-R stands for? Do they know about actions that FIMR has implemented?

___ ___ 8. Have you identified community leaders and organizations that can bring funding and other resources to help take recommendations to action?

___ ___ 9. Do you make sure to formally say thank you to all community members that have supported the FIMR process in even small ways?

___ ___ 10. Do you make sure to thank your FIMR team members for a job well done and make time to celebrate their successful efforts in taking recommendations to action?

Adapted from: Kerr DB and Hutchins E. Sustaining the FIMR program: a toolkit. NFIMR. Washington, DC: 2000, 89-90

Starting Where the Community Is: Maslow's Hierarchy of Needs

While Kretzmann and McKnight explain the importance of building the community from the inside out and tapping into the community assets to affect change, Maslow provides additional insight into factors affecting an individual or community's readiness to change.

Abraham Maslow, a psychologist who published his Hierarchy of Needs theory in the1960s, felt that existing behavioral theories in that area at the time were too negative (Freud) or too mechanistic (Skinner). In many ways, what Maslow proposed was a beautiful philosophy, rather than a method of psychoanalysis. He envisioned that at the highest level of achievement, or *self-actualization*, a human being would have values that encompassed truth, uniqueness, goodness, beauty, justice, order, and simplicity. He emphasized the positive potential for everyone to achieve human growth and mastery. (8)

According to Maslow, however, individuals must proceed step by step to achieve mastery. For example, individuals must trust that they have reliable food, water, warmth, shelter, and safety before they can focus on achieving self-actualization (See Figure 1 on page 28). Maslow identified five levels of human needs from the most basic to the most complex: (9)

1. Basic physiologic needs—required to sustain life: oxygen, water, food, bladder and bowel elimination, sleep, and protection from extreme temperature

2. Safety—being protected from harm, free from anxiety, and living in a milieu where order and routine are possible

3. Love and belonging—experiencing closeness, love and affection, being part of a group, identifying with a successful team

4. Esteem—feeling valuable and worthwhile

5. Self actualization—creating, understanding, achieving

Another concept Maslow explored is *synergy*: when a situation exists so that what helps the individual automatically benefits the whole. He expanded this concept to the community level. Community groups ought to aim toward the greatest synergy possible—all groups positively helping each other and benefiting the whole community. ▼

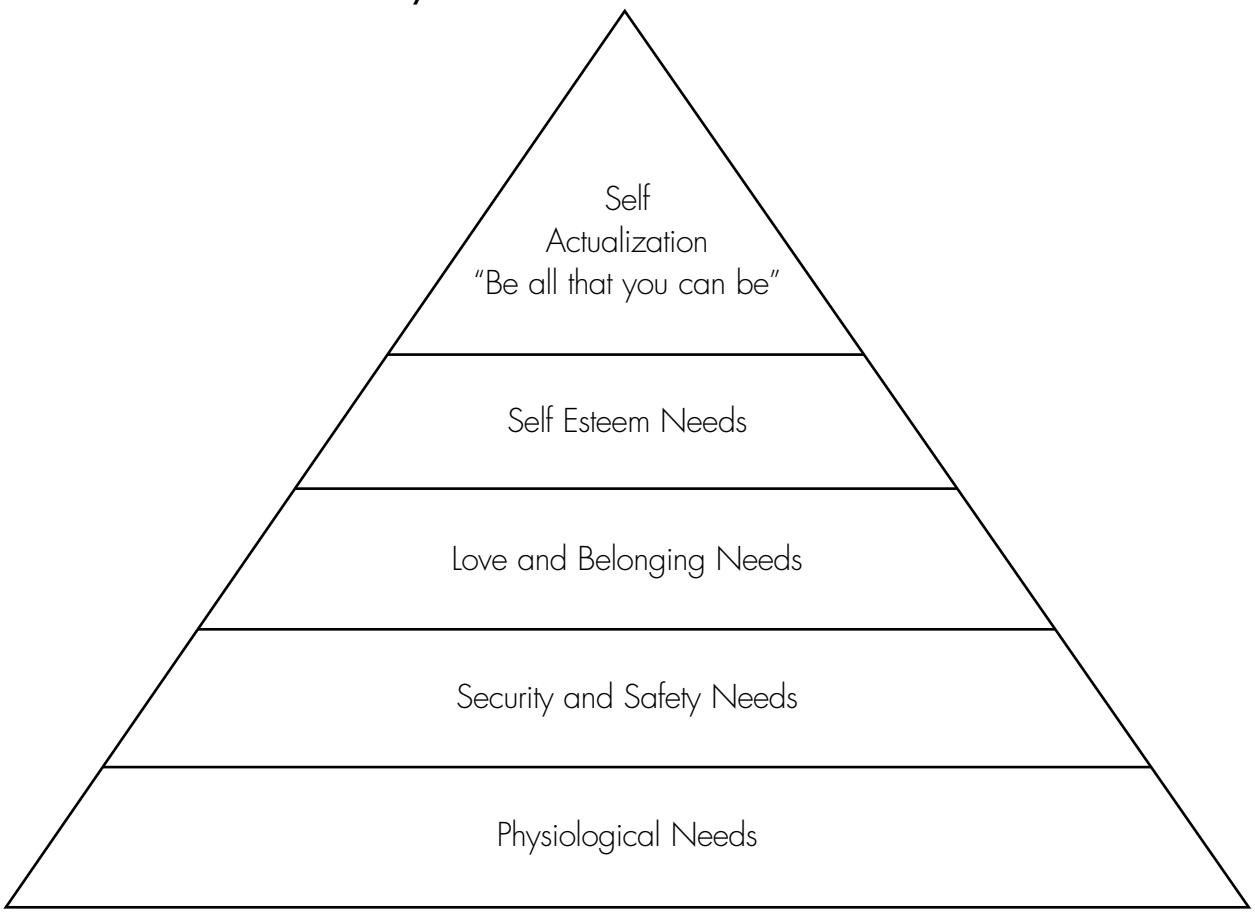
Maslow's Theory and FIMR

When a new FIMR has developed its first action plan, the team members may have a tendency to take community buy-in as a given. They may believe that the entire community will immediately want to support the FIMR community action plan because the issues the plan addresses are so critical. They may also believe that the community will see the FIMR program as a group of experts who have come together to help.

Indeed, infant and fetal deaths are critical issues, and each child that dies deeply affects the families involved and the community in which they live. However, Maslow's Hierarchy of Needs may help explain why a community may not be ready to buy-in to the team's plan and why the team's maternal and child issues may not always be a community's top priority.

In fact, Maslow's Hierarchy of Needs theory did not originally take into account a level for achieving community health. However, many say that achieving health has to come after the meeting of basic community physiological and safety needs. Maslow might say that this is not a utopian ideal, but rather a simple fact of being. Thus, before health is-

Figure 1: Maslow's Hierarchy of Needs



Maslow A. MOTIVATION AND PERSONALITY, © 1987 Adapted by permission of Pearson Education, Inc., Upper Saddle River, New Jersey

sues can be effectively addressed, ideally communities should have fresh air; clean water; nutritious food; affordable housing, and crime-free, economically sound neighborhoods. This concept may be overlooked in some health care delivery systems today.

Experienced FIMR programs also say that it is important for a new FIMR program to step back and begin an action agenda starting at the levels *where the community is* Sometimes community members identify their first priority as safety—having protected places for their children to play. Sometimes the priority is shelter—having better housing for families with young children. Rarely are the community's top priority issues phrased in terms of health care such as infant mortality, prenatal care, preterm labor, immunizations, or other maternal and child health issues, even though actions taken to meet a community's stated needs may also address traditional FIMR issues.

Maslow's theory has been applied to achieving individual health, as well. Thus, according to Maslow's theory, an expectant mother who is poor, hungry, socially isolated, living in substandard housing or an unsafe neighborhood would not be able to effectively focus on accessing prenatal care. Experienced FIMR programs have said that understanding this individual health level dynamic makes a difference. They are able to move away from blaming a mother for not seeking care to determining what systems should have been in place to empower her to achieve that level of self-actualization.

FIMR programs that underestimate or fail to understand Maslow's theory may run the risk of losing community support. With the best of intentions, some FIMR programs, which are not actually diverse

One Vision of "Self Actualized" Community Infrastructure

A strong economy provides ample jobs that pay a living wage. These jobs not only ensure that families have a decent standard of living, but provide health insurance benefits, as well. Community policing programs work with residents to keep neighborhoods safe. The housing market is affordable and non-discriminatory; making it possible for everyone to enjoy decent housing and for many to own their homes. An efficient, low cost transportation system connects all sectors of the community, including health care, social services and jobs. Nutrition security is possible for all families because every sector of the community has access to low priced, full service markets and WIC, supplemental nutrition programs, food stamps, school lunch programs and not for profit food banks are available to all in need.

The physical environment benefits from clean air, safe drinking water, carefully planned growth and parks where neighborhood families can gather and children can play. Health care services and community resources for childbearing and child-rearing families are available, easily accessible and culturally competent. High risk families are protected by a strong interagency safety net.

Young fathers have training and employment opportunities that, in turn, foster pride and family solidarity.

A policy and decision-making group with culturally representative, active community participation, such as FIMR, works closely with local, state and federal government to keep child and family issues top priorities and promote community cultural requirements. ▼

Adapted from: Melaville AI, Blank MJ. Together we can: a guide for crafting a profamily system of education and human service. Washington, DC: U.S. Government Printing Office, 1993:6-8

as they should be, may "go it alone", fail to engage the community, do not understand the levels that the community is focused on and create service systems that are disconnected from local priorities. As a consequence, the community will not use these services very much, no matter how appropriate they might be. Maslow would advise that FIMR programs must be extremely careful not to focus action on health service systems outside the community context or to disregard the community's priorities. FIMR programs must always see the broader picture through the community's eyes and remember to maximize the synergy between the community's priorities and the FIMR action agenda.

As has been said, experienced FIMR programs have found that the community may be much more concerned about addressing underlying situations, such as neighborhood safety, affordable housing or the availability of jobs, which ultimately affect health and illness, than they are about specific maternal and child health issues. However, this does not necessarily mean that they are unaware of the importance of these health issues. For example, about 10 years ago, the Florida FIMR programs surveyed women in local hospitals who had gotten little or no prenatal care. Prior to the survey, the FIMR programs had a preconceived notion that these women probably would indicate that they did not know about the importance of early prenatal care. In fact, every mother who responded to the survey indicated that early prenatal care was important. It wasn't that these mothers did not know this message; they did. However, many pressing problems basic to their welfare and that of their families had superseded their need for prenatal care.

The story that follows offers another example of how Maslow's Hierarchy of Needs theory may affect community planning and action.

Approximately 12 years ago, Florida's State Maternal and Child Health Program was establishing standards for Healthy Start Maternal and Child Health Coalitions. The mandate was narrowly targeted and focused: early enrollment in prenatal care, prenatal smoking cessation, infant immunization, etc. A Healthy Start coalition director in one of the rural counties had years of experience doing community-based work in education, social services, recreation, health, and many other areas.

The first few months that he was the Healthy Start director, the state office studied his first reports and seriously questioned his initial progress on implementing the mandates. He patiently explained that first he needed to spend some time in the neighborhoods where the women with poor outcomes lived, trying to gain the support of the community power brokers.

The Healthy Start director met with the neighborhood groups, the ministers in those neighborhoods, and the local school principals. Although all agreed that prenatal care was important, the priority of all the people in the community was neighborhood safety: the children couldn't play in the local park. The park had become a place where drugs were sold and the community was afraid that the children might pick up the used needles, or even become caught up in the drug scene. So the director collaborated with all the groups, tapping a variety of funding sources to clean up the park, get the police to do community policing there, and get the park department to put up lights.

Because the director was willing to work with the community, the community was willing to partner with the Healthy Start director in trying to take action to improve service systems and resources for the families that lived in the neighborhood. Working together, Healthy Start and the community set up tutoring services and transport that

helped people get to prenatal and other kinds of medical care providers. They set up baby equipment swaps, which provided a wonderful opportunity for moms that had "been there" to help the new moms and served as an extra support system helping families help each other raise their children and also helping to reduce child abuse in the process.

This experience is a good example of Maslow's concept of community synergy in action. Members of a new FIMR program who want to begin moving from recommendations to action must always think in terms of beginning at the level where the community is and of the synergy of their actions even if the program's earliest efforts sometimes mean working on a dual agenda that includes not only the team's health service system improvement actions, but also some more general community specific issues or problems. This example also explains why successful FIMR programs engage in a wide range of community actions. While the FIMR goal is improving health and human services, successful FIMR programs go further. They join with the community to address larger community problems. These joint ventures are a win-win strategy for FIMR and the community. ▼

Conclusion

Kretzmann and McKnight propose a model titled Assets Based Community Development (ABCD), which is an approach to community development based on making a paradigm switch from *documenting needs* to *discovering assets*. This switch involves identifying assets of public and private institutions, community associations, and individuals and then working to strengthen partnerships among all of those asset-holders to get things done. Learning from ABCD, the FIMR team membership must be truly diverse from the very beginning and seek out community involvement and assets to move from recommendations to action.

The FIMR program team members should also keep in mind Maslow's Hierarchy of Needs. Before they begin their work, FIMR teams must know which of Maslow's levels are the community's upper-most concerns. Experienced FIMR programs say that it is important for a new FIMR program to step back and begin an action agenda starting at the levels *where the community is*. The FIMR team may need to begin by putting in place community systems to address local security and safety needs at the same time as they develop a public health agenda. Assessing community priorities should be an integral part of recommendations and community action—even if that means thinking and acting outside the usual public health agenda.

In conclusion, the concepts proposed by Kretzmann, McKnight and Maslow can help FIMR team members to better understand the community and make it more likely that FIMR actions will be successful and sustainable over time. FIMR teams should consider these concepts in developing action agendas to improve service systems for women, infants and families. ▼

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http://www.northwestern.edu/IPR/abcd/orderform.html
The ABCD Institute at Northwestern University. ACTA Publications. acta@one.org. The following documents can be accessed there:

A Guide to Mapping Local Business Assets and Mobilizing Local Business Capacities

A Guide to Mapping Consumer Expenditures and Mobilizing Consumer Expenditure Capacities

A Guide to Mapping and Mobilizing the Economic Capacities of Local Residents

A Guide to Capacity Inventories: Mobilizing the Community Skills of Local Residents

A Guide to Evaluating Asset-Based Community Development: Lessons, Challenges, and Opportunities

- A Guide to Creating a Neighborhood Information Exchange: Building Communities by Connecting Local Skills and Knowledge
- City-Sponsored Community Building: Savannah's Grants for Blocks Story
- New Community Tools for Improving Child Health: A Pediatrician's Guide to Local Associations
- Online magazine from Health Canada promoting community health through empowerment. www.hc-sc.gc.ca/hppb/wired/community.html
- Dudley Street Neighborhood Initiative, www.dsni.org. They also have long and short versions of a film documenting their early ABCD work. ▼

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