

The People First Impact Method (P-FIM):

A community engagement tool to enhance relevance, effectiveness, protection, accountability to affected people, localisation, coordination and learning

- Personal reflection and experience on P-FIM exercises in Berlin, DRC and Kenya -

Background

Addressing the central recommendation from the World Humanitarian Summit 2016 of 'putting people first', the „People First Impact Method“ (P-FIM) is a cost effective and efficient way to ensure that humanitarian response is timely, relevant and appropriate, where communities play their rightful role and the dignity of people affected by crisis is respected. It strengthens local civil society and enables humanitarian actors to build on existing structures, instead of creating parallel ones. P-FIM allows communities to identify the important changes in their lives and what these are attributable to and reveals the wider dynamics within the life of a community.

In this case study Inez Kipfer-Didavi from Johanniter-Unfall-Hilfe shares her experience on P-FIM exercises in Berlin, DRC and Kenya by reflecting on the CHS commitments.

For further information, please consult Johanniter's P-FIM Report [in English and French](#)

Why is it important how we engage with communities (CHS #3)?

Because only a way of engagement that builds mutual trust with the communities allows us to gather quality information (data and how the people relate to the data) and thus a true understanding of people's realities, which is in turn a precondition for fitting interventions into ongoing community processes and adding value to what the community already does. It also reduces unrealistic expectations and distorted needs assessments. After P-FIM participants shared:

“If people are not asked for their “needs” and not made objects of a narrow targeting process, but informed transparently about the purpose of the discussion, and then asked about the important issues and changes in their lives, and really listened to, they do not come up with a “shopping list”, but with ideas for own actions and mature requests for external support. Based on the established trust with the agencies they have no problems in understanding the limits of agency assistance, and expectation management does not become a problem”.

“We need to base programmes on what matters to people and not on what we assume they need, as people will have no ownership if we do not engage them from the very start in a serious way”.

The process of a PFIM training & exercise

In order to organize a P-FIM training and exercise the agency invites local staff - who know the local culture and language - from local/national and international agencies active in the area of intervention as well as local government representatives (district officers, chiefs etc.) and representatives of the local community/affected population (f. ex. teachers, CBO leaders, midwives, community health workers etc.) to a 5-day workshop in the project area guided by an experienced P-FIM trainer. The agency may decide to hold such a P-FIM training and exercise in order to increase accountability to the affected people at any point of time before, during and after an intervention (see further below).

The workshop participants are trained during day 1 and 2 on why and how to engage the community. In teams of three they meet on day 3 with community groups (a broad range, selected by the participants) and invite them to raise and discuss the issues most important to them (goal-free discussion). They report back to the workshop participants what they learned and identify central issues from all meetings plus relevant agency questions, which they present the following day (day 4) to the same groups for further discussion. During these two-way discussions they ask what the community already does to tackle the issue, what they think they can do, and where they require additional support.

Results are shared among workshop participants, who then (day 5) reflect upon which lessons to be immediately acted on by one or several of the participating actors, and which to be advocated for with other stakeholders. At the same time, the fact of having been given space to discuss main issues, own actions and potentials and listen to each other as well as being listened to by the workshop participants is empowering to the affected community and often leads to further community action, independently of any agency support (or supported by agencies).

P-FIM was developed by Paul O'Hagan & Gerry McCarthy, <http://www.p-fim.org> and applied in 16 countries with over 300 organisations worldwide, in development, humanitarian and peace building contexts.

P-FIM is not a formal or technology-based mechanism, where beneficiaries of a specific agency project give feedback concerning the assistance received, i.e., where the agency and the project remain at the centre of attention, but an inter-agency, face-to-face, low-cost approach which reflects people's perspectives of their lives, among which our project might figure (positively or negatively) or not, depending on its relevance and impact for the people.

The P-FIM approach is relevant for enhancing social accountability during...

Assessment and project design (CHS #1): ensuring that project design is based on or connects to...

- the **capacities** and actions of the affected people instead of creating parallel structures (**CHS #3**): e.g. in DRC the insights from P-FIM enabled Johanniter to link the community transport of patients on foot to the road side for further transport by motorbike or car to health facilities with the ambulance and referral system;

“People themselves are now sharing solutions to issues. This is new. We faced a problem to assist those who are far from health centres and we came up with a solution. The community is willing to take their patients to the hospital and not wait for others to do so.”

Furthermore, P-FIM allowed Johanniter to consider the capacity of mutual savings groups to pay for hospital fees; the community also stressed the great importance they put themselves on community organization and self-initiative, an extremely relevant information for all agencies who often assumed the affected people of North Kivu to having become passive dependents on external assistance by decades of humanitarian interventions;

- their **priorities (CHS #4)**: in Turkana/Kenya both refugee and community representatives demanded agencies to better serve the host population, as their discrimination (compared to the services provided to refugees) leads to constant tensions and frequent violence; in DRC the population demanded urgently a blood bank and the improvement of the referral system to decrease maternal mortality, which was in the project pipeline anyway - but the fact that it was also a community priority placed ownership within the community; furthermore, during P-FIM the community groups spoke about the importance of community sensitization to address stigma and cultural taboos related to blood and witchcraft and how they are willing to play their part; also where the blood-bank should be located, and the importance of nutritious food for blood donors etc.
- an **understanding of local gender relations, power dynamics and associated risks (CHS #1)**: e.g. in DRC communities shared that the dramatic inflation of dowry badly affects the status of young women, contributing to gender based violence; in Turkana/Kenya the host population complained that their daughters “elope” with refugee men in order to escape hunger and thus their families remain without the traditional dowry or at least a compensation for the pregnancy of their daughters who drop out of school; girl refugees shared that many of them drop out of school due to language barriers, leading to increased teenage pregnancies and the spread of sexually transmitted diseases; in DRC women said that the lack of a local land registry combined with corruptive practices leads to land grabbing and impoverishment: *“when a powerful neighbor wants your land you must sell it”*. Orphans said they want witnesses to be protected as those who give evidence on corruption risk to be killed.
- their **insight into local vulnerabilities (CHS #1)**, to identify and include vulnerable and marginalized groups and to understand the causes and effects of marginalization from their own perspective: e.g. in DRC a result of the PFIM exercise was to include women and men from the stigmatized pygmy minority among the community health workers, in Kenya to ensure that the many street children of Kakuma town get access to health and water services.
- what the **locally accepted way of community consultation (and complaints management) (CHS #4 + #5)** by agencies should look like: in Turkana refugees and host population demanded transparent public meetings instead of agencies passing through key actors or local leaders; in DRC people suggested to form monitoring committees to be trained by agencies on how to follow-up on government or agency activities.

Project implementation and monitoring (CHS #2 + #7): based on the trustful relationship established during P-FIM the agency may engage in ongoing dialogue with the affected people throughout the project cycle:

- to discuss **culturally appropriate sensitization messages and channels**: e.g. for the introduction of a blood bank in DRC including required blood donations by the population; e.g. for sensitisation on assisted deliveries in DRC women requested “*we need support from those who can speak to our husbands to allow women to be treated by male health staff*”)
- **to learn how to adapt a program to new emergencies**: e.g. in a health outreach program in Turkana/Kenya to distribute food to patients from the host population during the drought in Kenya in order to enable them to come for necessary treatments
- **to learn how to better serve the most vulnerable**: in DRC the community requested psychosocial support for survivors of sexual violence, not just medical support, and people with disability shared their need for professional training, apart from health services.

Evaluation (CHS #7): Starting an evaluation with a PFIM exercise, discussing the insights with key informants and triangulating them with program documents and technical studies, helps...

- **to look at the project not through an agency lens, but based on an understanding of the reality of the affected people**: in Turkana the imbalance between destitute host population and relatively better served refugees risks to lead to violent conflicts; therefore it was good within the Johanniter refugee health project to have included outreach services - for ophthalmic, dentistry and orthopedic care - in the host community, but it became clear that much more needs to be done in terms of primary health care, maternal health and water for the host community, esp. in remote areas of Turkana; furthermore, the PFIM exercise revealed hidden vulnerable groups – the elderly among people living with HIV/AIDs as well as among people with disability, and street children – that had been overlooked so far.

P-FIM is an effective tool to improve coordination, complementarity and timely response (CHS #2 + #6)

P-FIM is an inter-agency approach, recognizing that we are not working in isolation. The aspect of participants from a great variety of agencies jointly listening to the voices of the community and learning from them, referring upcoming needs that they are unable to address to other stakeholders, brings all actors (including local and international agencies, local government and the affected community) closer together, creating a shared responsibility and enhances complementarity and synergies of local and international actors on the ground:

“P-FIM united us as people from different organisations and institutions and we could put aside our agency identities and badges.” (P-FIM participant in DRC)

It also enhances the visibility of disabled people’s organisations, women’s associations and CSOs and their embeddedness in the network of aid organizations. A Johanniter DRC manager shared:

“After the P-FIM exercise we used the intensified contact to the local umbrella network of disabled people’s organisations (which had also participated in the P-FIM exercise) to enhance our disability survey questionnaire to include questions directed to people with disability themselves to identify their priority needs. We also contacted an INGO specialized on disability to see whether we can refer patients with disability for physiotherapy to them.”

PFIM contributes to localization of humanitarian assistance (CHS #3)

During P-FIM people's own actions, initiatives and potentials come up to the forefront, and any assistance offered has to connect to these, thus strengthening local responders. In addition, as the participants in P-FIM trainings are always local staff from various actors and agencies, capacity is built at the point of delivery.

"We sometimes think that we are doing the right thing. I assumed that I know how to listen, but that was turned around. It starts with yourself. We have to listen to the voice of the community, the people we want to serve." "We used to take the assistance straight to the beneficiaries as we thought we already know. But there was a gap between us and them. We have to first hear their problem and their solution. People are able to solve their own problems, we just need to activate this, instead of bringing resources." (Participants from local NGO in Kenya)

P-FIM enhances inclusion and empowerment (CHS #1 + #4):

During the five-day P-FIM exercise representatives of vulnerable or marginalized groups are invited among the participants and thus contribute to the shared learning. When selecting the community groups for the listening exercises, they make sure that the most vulnerable are also met. Thus their voices are heard and listened to, both during community group discussions and when the participants jointly analyze the information gathered.

"Before the training, I thought I am nobody in the presence of chiefs and people from the district health office. The training changed everything as we were a team of equals." (DRC participant)

"The community knows so much more than I thought. Through listening to the Pygmies I realised how they are really discriminated against and marginalized." (DRC participant)

"The group of people living with HIV that we met really encouraged me to continue this kind of meeting as it is very encouraging for them as we listen to their voices." (Kenya participant)

"We see the agency vehicles moving up and down but we fear to go near them as we know we will be threatened by the police and people from the community. But if an agency can come and meet us where we are, the way that you did, then we will be happy to share the challenges we face as street children." (Street children from Kakuma, Kenya)

"If we listen to our people, we can heal our Nation!" (DRC participant)