

COMMUNITY DIALOGUES FOR HEALTHY CHILDREN

[encouraging communities
to talk]



The Learning Papers Series

Since starting operations in 2003, Malaria Consortium has gained a great deal of experience and knowledge through technical and operational programmes and activities relating to the control of malaria and other infectious childhood and neglected tropical diseases.

Organisationally, we are dedicated to ensuring our work remains grounded in the lessons we learn through implementation. We explore beyond current practice, to try out innovative ways – through research, implementation and policy development – to achieve effective and sustainable disease management and control. Collaboration and cooperation with others through our work has been paramount and much of what we have learned has been achieved through our partnerships.

This series of learning papers aims to capture and collate some of the knowledge, learning and, where possible, the evidence around the focus and effectiveness of our work. By sharing this learning, we hope to provide new knowledge on public health development that will help influence and advance both policy and practice.

Community dialogues for healthy children [encouraging communities to talk]

Author:

Sandrine Martin

Regional BCC Specialist, Malaria Consortium

Contributors:

Helen Counihan

Regional ICCM-CIDA Programme Coordinator
Malaria Consortium

Dr Chomba Sinyangwe

ICCM Project Manager, Malaria Consortium Zambia

Teresa Cerveau

ICCM Project Manager, Malaria Consortium Mozambique

Dr James Ssekitooleko

ICCM Project Manager, Malaria Consortium Uganda

Additional thanks to:

Eleni Capsaskis

Regional Communications Specialist, Malaria Consortium

Kalyani Prasad

Regional BCC Specialist, Malaria Consortium

Muhammad Shafique

BCC Specialist, Malaria Consortium Asia

Dr James Tibenderana

Technical Director, Malaria Consortium

Editor:

Diana Thomas

Senior Communications Manager, Malaria Consortium

Contact:

learningpapers@malariaconsortium.org

Community participants use the Interactive Poster and flash cards during a community dialogue, Mukomansala village, Zambia

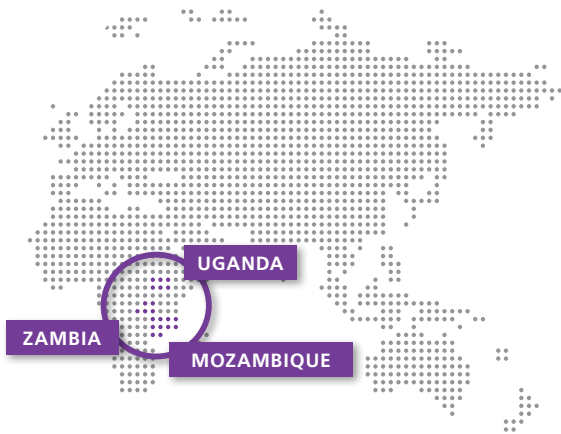




CONTENTS

- [2] Introduction
- [4] Community engagement:
a pillar for successful ICCM programmes
- [8] Community dialogues and ICCM
- [10] Design of a unique model
of community dialogue
- [16] Implementation process
- [19] Key questions and preliminary learning
 - Q1: Do community dialogues actually happen?
 - Q2: What are the challenges to decision making
and collective action?
 - Q3: Are trained facilitators able to run
a participatory dialogue?
- [26] Conclusion
- [29] References and further reading

Introduction



Community dialogues

This learning paper describes Malaria Consortium's approach to and experience of engaging local communities in integrated community case management (ICCM) in three African countries.

You hear about community dialogue but in fact very few organisations use this powerful approach, so it is important for us to share all we have learned with others

Dr James Ssekitooleko, ICCM Project Manager, Malaria Consortium, Uganda

This paper looks at some key barriers to the early treatment of sick children identified by Malaria Consortium and the interventions developed to address them, with a focus on the community dialogue (CD) approach.

The potential of CD to improve health outcomes has been largely recognised by practitioners and researchers. However, examples of how this works in practice in the ICCM context are rare. This paper describes the model developed by Malaria Consortium to trigger genuine dialogue within local communities about the management of selected childhood diseases.

Initial lessons from the early stages of community dialogue implementation are outlined and it is proposed that an evaluation of the experiment should be allowed to contribute to efforts to identify good practices for effective community involvement in ICCM programming.

Communities already often come together to discuss issues of concern in their areas, either regularly or on an ad hoc basis. The CD approach is a mobilisation and empowerment process aimed at using these existing meetings to provide communities with information, skills and confidence to gain control over decisions about their own lives.

Integrated Community Case Management

Over 50 percent of childhood illnesses in sub-Saharan Africa can be attributed to diarrhoea, pneumonia and malaria - diseases that are relatively easy to diagnose and treat yet remain the primary cause of deaths in children under the age of five. The carers of these children, however, are often unable to access functioning health facilities. Integrated community case management (ICCM) - an approach where community-based health workers are trained to identify, treat and refer complex cases of children with these diseases - is increasingly being used to supplement these gaps in healthcare provision. ICCM programmes have been endorsed by major international organisations and donors, and many African Ministries of Health as a key strategy for reducing child mortality.



Community engagement: A pillar for successful ICCM programmes

Malaria Consortium has been implementing ICCM in four African countries – Mozambique, Uganda, South Sudan and Zambia – since 2009. It has been working in partnership with Ministries of Health at national and local levels, through a three-year grant from the Canadian International Development Agency (CIDA). The CD approach described in this learning paper has been implemented in Mozambique, Uganda and Zambia as part of Malaria Consortium's ICCM engagement in the region.

Communities and care-givers' support for and use of community-based services is one of the four pillars for prompt and effective community-based case management, and identified in Malaria Consortium's ICCM programme plan.

Indeed, community involvement has been recognised as one of the most important factors in enabling health interventions to be successful (see References).

Key issues in community engagement

As part of its community engagement work, Malaria Consortium conducted extensive stakeholders' consultations and community sensitisation before the ICCM programme officially began.

In close partnership with Ministries of Health at various levels, Malaria Consortium facilitated communities' involvement in the recruitment of volunteers to serve as community based health workers (*Agentes Polivalentes Elementares* in Mozambique and Village Health Team members in Uganda) in line with existing national policies and guidelines.

REDUCE SEVERE CASES AND DEATHS

PROMPT AND EFFECTIVE CASE MANAGEMENT

Community and
parents support
and use

Quality and
functional community
based services

Health
system
support

Supportive policy
environment for
sustainable ICCM

Qualitative research was also conducted in each of the four countries during the first phase (2010) of the project. This looked at existing knowledge, attitudes and behaviour in relation to the prevention and management of diarrhoea, pneumonia and malaria in children. The results indicated that ICCM was accepted by community members. However, it also highlighted that most care-givers do not believe they have the capacity to give medical treatment to their children when they are ill. It also showed there were gaps in knowledge about the management and prevention of these diseases.

In reality, most of these rural communities tend to have only a vague involvement with modern medicine. This is due to the distance between villages and health facilities, as well as the fact that rural populations often have little accurate knowledge about health.

The studies also confirmed that access to information about health is mainly at health facilities, which are normally only used when a woman is pregnant or a child is severely sick.

Before the ICCM project began, more research was carried out by Malaria Consortium under the auspices of the Bill & Melinda Gates Foundation funded inSCALE project in Uganda and Mozambique. This research also highlighted a lack of community support and involvement in the programme, reflecting low levels of community awareness and appreciation of the community health workers' (CHWs) roles and responsibilities.

Community sensitisation: district local authorities visit rural communities to explain and discuss features of the CHW programme. Massinga district, Inhambane, Mozambique



In addition to these findings, a mid-term survey conducted in 2011 in the Western Region of Uganda showed that despite high levels of awareness of the CHWs' role among community members, the use of CHWs' services remained low (around 37 percent), compared with health facilities (either public or private, close to 60 percent). The rate of care-seeking within the first 24 hours of illness also was too low. These results are a clear indication that training and equipping CHWs to provide services are not enough to trigger their use, let alone encourage care-givers to seek prompt treatment.

Therefore the main challenge remains to reach out to these rural communities and to provide them with opportunities to access basic health information on both disease prevention and care options. Also, and

more importantly, it is to discuss how this information applies to their daily lives and their own perceptions of disease prevention and health care.

Despite the fact that the three countries have mostly developed national frameworks for health promotion and community involvement in health, the "how to" element for actual implementation is often lacking. For example, in Mozambique the Ministry of Health policy states that health committees should be formed by communities to represent their needs when it comes to issues such as health promotion, prevention and treatment, which would also link them to essential services. However, the strategy is in its nascent stages, and committees are usually weak or non-existent.

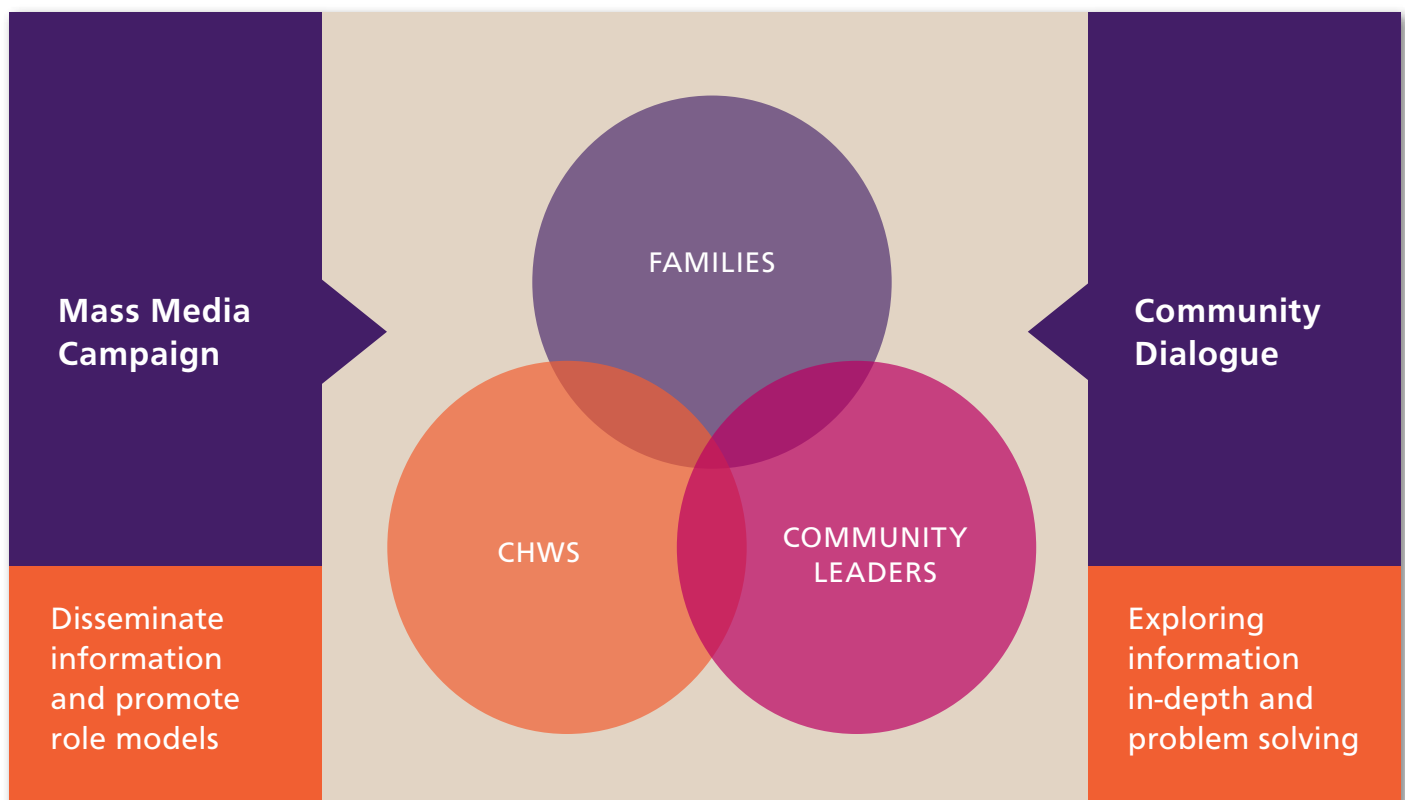
Examples of common barriers to seeking appropriate treatment:

- relying on home remedies (such as traditional herbs or paracetamol bought at local markets) to relieve symptoms
- associating convulsions (often caused by severe malaria and very high fever) with witchcraft
- consulting traditional healers in the first instance, rather than medical practitioners
- an inability to differentiate between pneumonia and asthma
- a tendency not to complete treatment when given drugs for a specific condition and keeping medicines for later or sharing with other sick children
- difficulty in differentiating between simple and severe forms of disease

Malaria Consortium's response

To address these issues, in 2011 Malaria Consortium designed a public health communication intervention, ultimately to enable care-givers and communities to make improved choices for children's health and survival through individual and collective actions. The intervention is based on a socio-ecological approach, which sees individual behaviour as the result of overlapping individual, social and environmental issues. It also seeks to address social norms around health-care seeking and prevention practices around child health. The intervention combines two main complementary strategies:

- the diffusion of information through mass media (radio programming and posters), focusing on the availability of CHWs, their services, and the importance of early care-seeking
- Community dialogues aimed at providing communities with opportunities to discuss extensively within their villages, newly available healthcare services and how community members can best benefit from and support these services.



Community dialogues and ICCM

Malaria Consortium views CHWs not only as distributors of drugs but also as a means to strengthen the link between communities and formal or informal health services.

At the core of the CD approach is Malaria Consortium's focus on building trust and cooperation within communities and between communities and the health system as a key determinant for early care-seeking in the event of child illness and for better health generally.

Malaria Consortium sees CD as a key way of encouraging community members and groups to interact and discuss features of the new health services made available to them. It enables them to access basic information on the causes, prevention and treatment of targeted diseases. It also helps the community address the challenges and needs affecting the health of their children.

The power of community dialogue

Participatory learning and action approaches, and other ways of mobilising the community that are based on knowledge and competency, have proved to be reliable and effective ways of engaging people in various projects. They take into account a community's capacity to address its own problems, as well as a set of processes that enable dialogue, analysis, planning, sharing and evaluation.

Various models of CD have previously been successfully implemented in a number of developing countries, especially for addressing resistance to immunisation (Nigeria, UNICEF), malaria prevention and more recently for HIV/AIDS prevention (Community Conversations, C-Change/USAID).

However, despite consensus among field practitioners that CD is essential, few ICCM programmes have formally developed models for implementing these dialogues.

Key requirements

Malaria Consortium, in line with its commitment to engaging communities in programme implementation, needed to develop a flexible community dialogue model with the potential to address the following:

- The need to trigger community engagement, with a focus on building trust and cooperation through community understanding and support to the CHWs' services, and early care-seeking.
- The need for a flexible model which could be adapted to various country contexts and scales of operations in Mozambique, Zambia and Uganda, and in line with national policies and guidelines.
- The need for practical guidelines to make national frameworks on community mobilisation work for ICCM programmes.
- The need to propose a simple model and develop easy-to-use tools which would not require skilled external facilitators, building on existing community-based structures, so that the model could eventually be adopted by national Ministries of Health and / or other implementing partners.



Design of a unique model of community dialogue

Community dialogue framework

The overall objective of CD is to contribute to improving health practices for timely and optimal management of childhood diseases through ICCM services.

Taking stock of research about community engagement in health, and more specifically about community dialogue and collective action conducted in the field of social development, Malaria Consortium developed a unique model for triggering regular CDs in communities where ICCM is being implemented. This was done by providing:

- **a stimulus:** giving selected community leaders and CHWs a basic one or two days' training on facilitation skills and a CD toolkit
- **an innovation:** giving communities accessible child health services through training, equipment and supervision of CHWs for ICCM
- **a limited mass media intervention:** using radio messages and posters focusing on the availability of CHWs, information about the diseases and the benefits of seeking medical care early

Community dialogue process

The primary participants in CD are parents and care-givers of young children; CDs are also open to other community members, especially "gate-keepers" such as elders and religious leaders.

Dialogues are chaired by community leaders and co-facilitated by CHWs, both of whom receive one to two days training on facilitation skills, plus a simple toolkit (guidebook, discussion guides and flash cards).

Ten simple steps are proposed to organise and lead fruitful community dialogue sessions. These should be focused on one topic and comprise three core phases:

- Exploring the topic: questioning assumptions, filling knowledge gaps, clarifying misconceptions

- Identifying issues: reflecting on personal experiences of childhood diseases' management and prevention
- Action planning: agreeing on a few achievable individual or collective actions to ensure prompt, high-quality medical care for young children as well as appropriate ways to prevent these diseases

Four key topics are proposed and discussion guides provided: CHWs' services, malaria in children, pneumonia in children, and diarrhoea in children. CDs are expected to be held regularly, at the pace chosen by each community, but at least covering the four key topics within a 12-month period. Their success is dependent upon the partnership between community leaders and CHWs; these community-based facilitators do not receive any stipend for conducting dialogues.

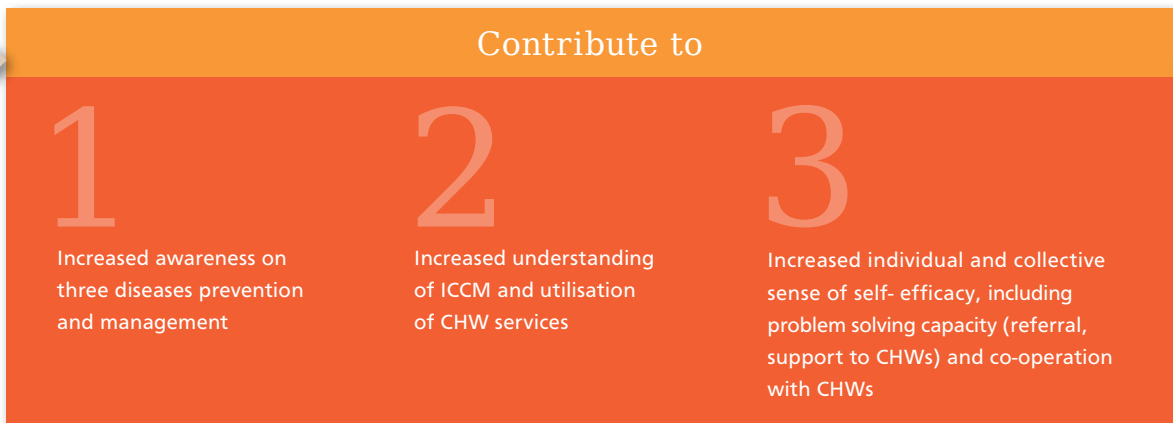
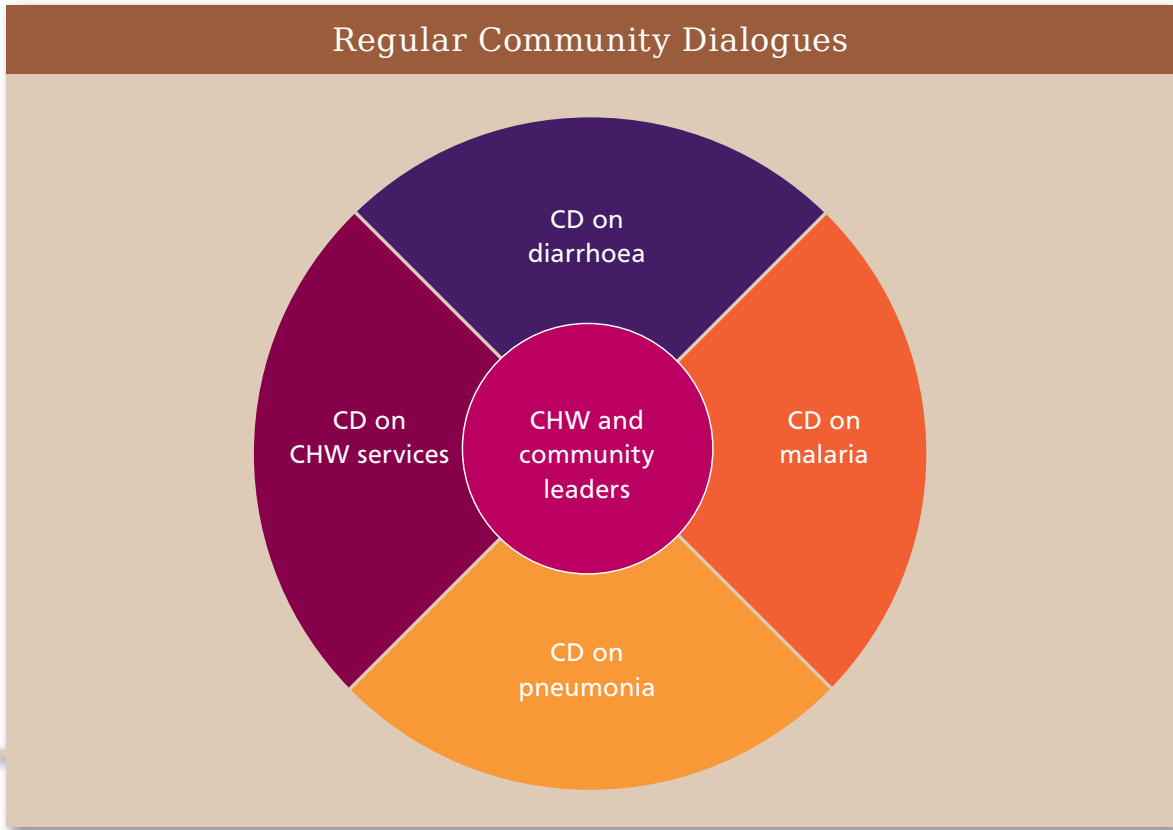
Key features of the community dialogue approach:

- addresses lack of opportunities to discuss in-depth health-related information and recommendations within the communities
- triggers genuine dialogue and locally-driven individual and community actions
- is anchored in the voluntary partnership between CHWs and community leaders
- increases outreach of facility-based or mass-media communications, especially for communities who have limited access and use of such channels
- discusses the feasibility and applicability of health information and services
- is action-oriented but not prescriptive, allowing communities to identify their own issues and resources



Community dialogue co-facilitated by community leader and CHWs

Primary participants are parents and care-givers of young children



Leading a community dialogue: 10-step process

 Before a community dialogue

 During the dialogue

 At the end of the dialogue

1 Read your community dialogue toolkit



Select one topic to be discussed per meeting. You can ask a community health worker for help to make sure you understand all the information and clarify any.

4 Introductions



Each dialogue starts according to the protocol which would normally be used at a community meeting. For example, it could start with a prayer, an introduction of the purpose of the meeting by the chairperson, and introductions from participants (if they don't already know each other).

5 Exploring



Explore the topic by asking open questions, using examples in the Discussion Guides. Involve everyone by asking each participant to share their thoughts. Use the information about "what parents need to know" to clarify and correct misconceptions about the topic. The CHW can answer additional technical questions that arise.

7 Action planning



After participants have expressed their opinions on the best options to care for a sick child, ask participants to agree on a few specific actions for individuals and for the community to help reduce sickness and death among children. Make sure to identify who is to do what, where and by when for each action. Try to involve everyone in the discussion in at least one action.

8 Summarise key discussion points



Remind everyone of the action plan developed, including the topic and timing for the next community dialogue.

2 Ensure at least one CHW attends the dialogue



If possible, try to get a professional health worker to participate in the community dialogue to answer technical questions from community members.

3



Agree on the date, time, location and topic and invite community members to attend. Avoid inviting too many participants; it is better to keep the group to 10–20 people.

6 Identifying issues



After participants have explored the topic, place the large poster in the middle, either on the ground or on a table. Place the small cards randomly around the poster. Then ask participants to tell their story using the small cards, placing them on the large poster to illustrate what usually happens, based on their own experience as parents. Try to identify two to three challenges within the community that affect the topic you are discussing.

Then ask participants to suggest ways they can work together to address the identified challenges. Encourage participants to focus on what they can do within their community, rather than focusing on what they want others (such as the government) to do for them.

9

Rural Health Center



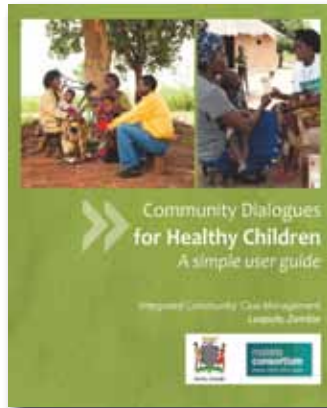
Refer participants to CHWs, health workers or health centres for more information, assistance and services.

10 Thank you!

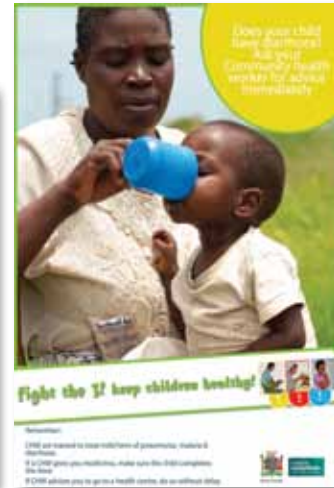
Thank participants for coming, listening carefully and sharing their views.

Community dialogue toolkit for ICCM

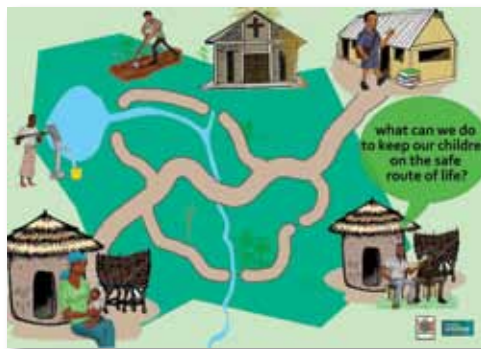
Community leaders and CHWs trained in the CD approach are equipped with a basic toolkit comprising a guidebook (including definition, process, 10-step methodology and discussion guides) and flash cards. The toolkit contents were adapted to each country context. The following resources were developed and distributed.



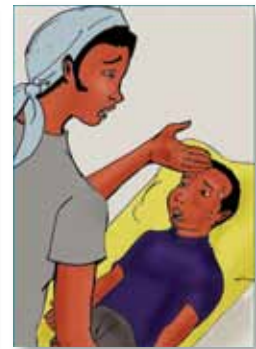
CD manual - Zambia



Diarrhoea poster - English



Interactive poster



Flash card

Zambia - 2012	Mozambique - 2012	Uganda - 2012
<p>Facilitator Guide for one to two days' training of community leaders and CHWs</p> <p>Language: English</p>	<p>Facilitator Guide for one to two days' training of community leaders and CHWs</p> <p>Language: Portuguese</p>	<p>Facilitator Guide for one to two days' training of community leaders and CHWs</p> <p>Language: English</p>
<p>Community Dialogue Guidebook</p> <p>Language: Bemba (English electronic version available)</p>	<p>Community Dialogue Guidebook</p> <p>Language: Portuguese</p>	<p>Community Dialogue Guidebook</p> <p>Language: English</p>
<p>Interactive poster and flash cards</p> <p>Language: Bemba (English electronic version available)</p>	<p>Flash cards</p> <p>Language: Portuguese</p>	<p>Flip chart</p> <p>Language: English</p>



Implementation process

.....

The implementation process comprised a piloting exercise, followed by phased training workshops in targeted districts, and qualitative monitoring of CDs in each of the three countries.

.....

Piloting

The model was first piloted in Mozambique (February 2012), followed by Uganda (March 2012) and Zambia (April 2012) in close partnership with district level health authorities.

The piloting exercise consisted of a one-day training of potential community-based facilitators (community leaders and CHWs), followed by a CD trial in selected areas. The approach was evaluated against specific criteria:

- understanding and relevance of the CD approach to community-based facilitators
- convenience of the toolkit, training module and monitoring checklist
- applicability of the CD 10-step process
- trainees' facilitation capacities and gaps after one-day training
- overall relevance and acceptability of the approach and suggestions for fine-tuning

Results of the pilot

The piloting was a critical phase: not only did it allow for fine-tuning the model, but was also essential to familiarise the district level health authorities with this kind of participatory approach to community mobilisation. The main lessons were as follows:

- During the trials, the actions of the CHW the community leaders complemented each other, with the CHW taking the lead on disease-related topics, and the community leaders organising the discussions.

- The approach was appreciated by local health authorities and community-based facilitators, as well as community members. Trainees were particularly enthusiastic about the participatory approach and participants recommended that the approach be scaled up to all districts and villages.
- In Uganda, the trial helped to refine the approach. The piloting exercise showed that it would be difficult for Parish Coordinators (peer selected representatives for a cluster of CHWs) to be engaged in CD facilitation, as they were responsible for a number of villages and do not have transport to travel between them. Instead, it was decided with local health authorities that CD trainings should target CHWs, prioritising those serving the most remote and deprived communities.
- The main challenge faced by CD facilitators was to keep the discussions focused on one topic in order to go through the three stages of the dialogue (exploring, identifying issues, and taking actions). They needed to keep this focus until feasible actions that could be taken with the resources and services already available were identified.
- During the CD trial, the discussions took the form of a genuine dialogue where participants shared their own personal stories and perceptions, including misconceptions about diseases or treatments. CHWs were not always able to answer and correct misconceptions. It was therefore recommended that the Monitoring Sheet for CHWs be added. In that section, they could record all the technical questions they could not answer or had doubts about during the dialogue, forming the basis of a technical update with their respective supervisors.

It is the first time that I have practised dialogue, so I need to do it more often. But I enjoy it because it is more engaging than health talks; there is more exchange of ideas during a dialogue

Community leader, Samfya,
Luapula, Zambia

- Minor changes were included in the toolkit layout and wording to ensure readability to low-literacy audiences. For the Training Guide, it was decided that the training should be at least one and preferably two full days.
- In Zambia, some community members were “protective” of the interactive materials, fearing they might get spoiled if too many people touched them. These colourful materials are indeed relatively rare in the community.

Training

The one or two days’ training given to community-based facilitators consists of a basic orientation based on the CD toolkit. It uses participatory brainstorming sessions, practical exercises and role play to build on trainees’ skills. Its contents focus on the CD approach and how it differs from health education sessions, the 10-step process and basic facilitation tips.



.....

“

The dialogue was just wonderful. This is what should be happening instead of only discussing politics in community meetings. We learned a lot of new things and corrected our misconceptions about malaria and especially the mosquito. Now I know that only the mosquito causes malaria and nothing else and that early treatment is important and not to use traditional medicines first. We should always ensure our children eat early and tuck the mosquito net very well so that mosquito does not go in

”

A female participant gives feedback on the community dialogue in Mukomansala, Zambia

.....

Monitoring

Two simple tools have been developed to document the process and lessons learned:

1 For monitoring the process:

A *Community Dialogue Monitoring Sheet*, to be filled after each dialogue held, by the CHWs.

The sheet allows basic data - such as attendance, topic discussed, main decisions reached, and difficulty or unanswered technical questions – to be recorded. CHWs report to their supervisors on the dialogues undertaken during monthly supervision meetings. The Monitoring Sheet includes a section to record any technical question raised or not answered during the dialogues as a basis for supervisors to correct and/or fill knowledge gaps of CHWs. This information is kept for reference at district level.

2 For collecting qualitative data:

A community dialogue Observation Form, to be filled in by Project staff during planned monitoring visits to project sites.

The form includes the description of CD proceedings, a focus group discussion with some participants, as well as a feedback session with facilitators. It helps observers to look at specific features of the CD approach, namely:

- the application of the 10-step process detailed in the CD guidebook and training (see pages 12–13)
- the relevance and attraction of CD for participants and facilitators
- the CD facilitators' skills, including their feedback on the training and tools

On average, project staff observe one or two dialogues per month. During these observation visits, project staff also provide guidance and technical advice to community-based facilitators. However, supportive supervision and mentoring to all trained community-based facilitators is not part of the model.

Through this qualitative monitoring and observation of CDs, Malaria Consortium also aims to listen to communities' concerns over ICCM programming. By bringing along district health authorities on the observation visits, Malaria Consortium likewise encourages local health authorities to respond to communities, thereby increasing accountability on both sides.

Key questions and preliminary learning

Initial qualitative results, drawn from monitoring activities, are expected to be available by early 2013. These will be complemented by data collected through a household survey at the end of the project, which will provide information on how much CHWs are used, the levels of awareness of their services among care-givers, as well as perceived trust in their services.

Through its monitoring of the community dialogue process, Malaria Consortium is looking specifically at three main questions:

- 1 Does this simple low-cost implementation model actually trigger community dialogues to happen in the communities? How regularly? What are enabling factors and barriers?
- 2 What are the challenges to decision making and collective action within communities?
- 3 Are the trained CD facilitators actually able to run a participatory dialogue or do the sessions become more about 'sensitisation' without further discussion or interaction?

Some preliminary findings drawn from the implementation of the trainings and observation of a few community dialogue sessions follow.



Question 1:

Do community dialogues actually happen?

“

This programme is interacting directly with the communities themselves, while other programmes usually end up at health centre level and the communities feel left out. Personally I am very impressed with the programme and it is my wish that it continue

”

Mr Ndlobvu, Clinical Care Officer,
Mwense district, Luapula, Zambia

An engaging approach

Initial feedback indicates that the CD approach is highly appreciated by community-based facilitators, community members and health centre staff. Because it is grassroots-based, reaching out to communities, it allows 'ordinary people' to interact and reflect on health information within their villages and not at health facilities, where such interactions usually happen.

Not all community members have access to radio or a phone to participate in radio phone-in programmes. Others, because of low literacy, can misinterpret posters. Participants are encouraged at CD sessions to express their views, ask questions and tell their own stories and do so freely because the session is facilitated by peers rather than professional health staff.

Participants also said that they felt valued because they are given colourful materials that they can keep for their own use (Zambia). In hard-to-reach areas, where communities often feel 'neglected', community leaders noted that, through this project, they have the sense that 'someone is taking care of them' (Uganda).

Observation of community dialogues in Zambia shows that the participatory discussion based on sharing of personal stories by care-givers allows people to discuss traditional beliefs, such as convulsions being associated with witchcraft. It also enables them to understand the risks of delayed care-seeking through learning from the experience of others.

Observation in Uganda indicated that such dialogues are helping community members to appreciate better the value of services offered by CHWs, which is a key motivation factor for volunteer CHWs to continue their commitment.

The key role of community leaders

Engaging community leaders is essential in ensuring that CHWs have regular opportunities to present and discuss basic health information, which can be complemented by community 'gate-keepers'. Despite enthusiasm for the approach, there are some risks associated with using voluntary facilitators.

Because the model is anchored in the voluntary partnership between CHWs and community leaders, how well this works depends to a large extent on the relationship between the community leaders and the CHWs, and their availability, willingness and skill.

Community-based facilitators undertake a planning exercise and are given at least five copies of the CD Monitoring Sheet at the end of the training as an encouragement to hold at least one community dialogue on each topic.

Anecdotal observation in Mozambique indicates that CHWs seem to be more committed than community leaders to hold regular CDs, as they feel it is primarily their role and to their benefit.

Every community is unique and complex with varied levels of cooperation, conflict, community organising skills and social capital. Communities' abilities to organise themselves, reach consensus, mobilise resources and people will depend greatly on the different and ever-evolving structures of each community. The leadership skills of local leaders – traditional, administrative or religious – are thought to determine the success of the whole process.

Linking rural communities with health services

Keeping a regular link between community health workers and facility-based health supervisors for regular technical updates helps to ensure that the health information given out at community-level is correct and that misconceptions can be addressed. This link is critical for ensuring that CHWs can provide new health information based on people's questions and issues of concern, and thus keep their audience engaged in regular dialogue.

The CD Monitoring Sheet allows CHWs to record doubts and questions, which are addressed by professional health workers during monthly supervision sessions. Where this supportive supervision system works well, both health workers and CHWs appreciate this list of questions as a basis for discussion.

Indeed, anecdotal evidence from Mozambique indicates that care-givers appreciate the role of CHWs as 'interpreters' of health advice received from professionals, because they are able to translate it into ordinary language.

In Mozambique, each CHW trained in ICCM is equipped with a drug kit which typically contains a torch for night visits, latex gloves, a respiratory timer, rapid diagnostic tests for malaria, a MUAC (mid-upper arm circumference) tape to assess acute malnutrition, and essential drugs in paediatric formula



Question 2: What are the challenges to decision making and collective action?

.....
“
I will work as a community facilitator and will lead by example. The training has been really good, but we need to learn more and to practise more

Mwaba Sereje, community-based facilitator, Mwense district, Luapula, Zambia

.....
“
I cannot manage to buy a mosquito net, charcoal or firewood to boil water. Boiling water takes time, I cannot afford to buy a clear and clean bucket, buy chlorine, etc. I just do not know where to go when I need support. I fear being laughed at because I do not have nice clothes to wear when going to the health centre. I fear the nurse will shout at me

Female community dialogue participant, Zambia

Community dialogues are expected to be action-oriented. However, changing the way care-givers prevent and manage illness at home is particularly challenging in communities with low literacy, limited health information, distrust of the health system, limited resources, strong traditional beliefs and poor access to national health services.

”
Preliminary findings indicate that CD is a useful tool for identifying gaps in information and addressing them. But for individuals to move from information to action is not a simple process. It may also require addressing social norms and encouraging individuals to make positive changes.

Knowledge gaps

Indications are that, because of low though variable health literacy among community members, the community dialogue sessions tend to focus on the ‘exploring’ phase to fill in information and knowledge gaps, with little time left for identifying issues and action planning.

In time, as members of the community gain knowledge and facilitators gain experience in leading dialogues, it is expected that discussions will move progressively towards problem solving.

Social norms

Testimonies from CD participants indicate that the availability of local CHWs is not enough to change the ways participants seek medical care, but that community dialogues can be a platform for progressively addressing social norms through discussing common values and learning from peers’ experiences.

The social norm is to start by treating symptoms at home, with traditional herbs, and in some cases also consulting traditional healers. Only then, if at all, will care-givers seek medical attention. For example in Zambia, where convulsions in children are often associated with witchcraft and not necessarily with severe malaria, care-givers would seek help from the traditional healer in the first place, thus delaying access to life-saving treatments available through the CHW.

“

This is the second community dialogue we have held. We want to know what people in the community think about health issues and what they know about health prevention. [CHWs] then share their knowledge with other community members so that they can improve their own skills and prevent disease. The dialogue allows community members to share ideas, rather than just be told something

”

Silvestre Jose Xavier, Prevention Medicine Agent, Vulcanjane community, Inhassouro, Mozambique

Size of the group

Another challenge is the size of the group. There is a tendency among community-based facilitators to hold large group sessions, with the assumption that the success of the session can be gauged by the number of participants. Also, because there are so few opportunities to discuss health information at the village level, when such an event is organised, more and more people join the discussion as they notice there is a gathering. There can be up to 60 people involved.

Lack of resources

This is the primary barrier stopping people taking effective steps to prevent disease. Preventing malaria requires mosquito nets; preventing diarrhoea needs boiling water, which requires charcoal or firewood, as well as soap for hand-washing. Communities are often reluctant to invest their meagre resources in preventive measures.

Community dialogue hopes to encourage people to shift their way of looking at health from one focusing on problems and needs, to an approach based on appreciating and building on their own strengths. For this approach to be effective, it has to be linked to increased access to ICCM and other preventive services.



Question 3:

Are trained facilitators able to run a participatory dialogue?

“

It was really nice to see how community members, especially men, fully participated in the discussion. It was easy for them to discuss the barriers and advise each other on what to do in a very collaborative way

Patricia Siakanomba,
Malaria Consortium,
community dialogue trainer

”

Tools versus training

Unlike health sensitisation sessions, CD puts the emphasis on questioning and re-evaluating assumptions. This should make it easier for facilitators to deepen understanding and clarify viewpoints and misconceptions on the part of participants. Dialogue is about listening and provides communities with platforms for exchanging information, personal stories and experiences, leading to the development of common values and solutions to community concerns.

It is usually assumed that running a dialogue requires more facilitation and group discussion skills, and therefore more or longer training of community-based facilitators. Malaria Consortium's experience shows that giving visual interactive tools to low-literacy facilitators allows them, in fact, to overcome barriers and interact with community members.

Experiences from implementing the CD approach in Zambia and in Mozambique shows that giving visual tools to facilitators makes a huge difference. In Mozambique, CDs started as early as April 2012, when the final package of flash cards was not yet finalised or distributed. It was observed, however, that CD sessions may not be fully participatory when facilitators do not have visual tools that can be passed around and commented upon by those taking part.

In Zambia, on the other hand, materials were distributed during the training itself. The community-based facilitators felt much more at ease running a genuine dialogue. The materials are specifically designed to allow all participants to touch and play with the cards to tell their personal experiences, but also, through collaborative discussion, to reach agreement on what to do when a child is ill.

Using local languages

It is essential to use local language in the materials designed. However, it is challenging and costly to produce materials in three or four different languages in areas where there are several local languages. As a result one commonly used language, such as English in Uganda or Portuguese in Mozambique, is used in the printed materials, while verbal communication during community dialogue trainings is done using the relevant local language.

In Uganda, where at least four different local languages are used in the Western Region, the CD Guide was designed in simple English. Given the low level of English of some community-based facilitators, it is essential to go through the guidebook in detail during the training in order to clarify the contents and translate into local languages.

In the Luapula province of Zambia, several local languages are spoken but it was possible to use Bemba for all designed materials, as it is spoken and understood across the province.



Conclusion

Malaria Consortium has developed a flexible community dialogue model using simple visual interactive tools adapted to low-literacy audiences. The model aims to involve members of the community and requires little external support. It focuses on building trust and cooperation through community understanding and support for the CHWs' services, as well as the promotion of early care-seeking.

Training and equipping CHWs to provide services are not enough to trigger appropriate use by community members, let alone change when and how they seek care. The CD approach, however, is considered critical for triggering community uptake of and support for ICCM services.

Preliminary findings drawn from the early stages of implementation in Uganda, Zambia and Mozambique show that CD has been very effective way of identifying and filling information gaps. The use of visual interactive tools and of local languages seems to enable community-based facilitators – who receive only a basic training – to generate participatory discussions through questioning and sharing of testimonies among care-givers.

The model supports engagement with rural communities, providing them with opportunities to access basic health information on both disease prevention and care. Also, and more importantly, it provides an opportunity for them to discuss how this information applies to their daily lives. Feedback from the first of these CDs indicates that the approach is highly appreciated by community-based facilitators, community members and health centre staff. It is grassroots-based and allows participants to interact and reflect on health information within their villages.

Moving from information to action is not a short or straightforward process, however. It also requires addressing social norms and empowering individuals.

It is essential that the capacity of local health services, especially at district level, continue to be strengthened in participatory approaches such as CD to allow them to support community-based facilitators. Having received only a basic training, community-based facilitators need both practice and coaching in order to gain the confidence to lead CDs that are both regular and successful.

Further evaluation

This CD model needs further evaluation by stakeholders at all levels of expertise and involvement, from care-givers to Ministry of Health staff. This will encourage them to appreciate better the potential strengths and shortfalls of CD in generating community involvement. The evaluation should also include a cost analysis and community capacity assessment to make recommendations for strengthening the community mobilisation component of the basic ICCM programme implementation guidelines in the countries.



About Malaria Consortium

Malaria Consortium is one of the world's leading non-profit organisations specialising in the comprehensive control of malaria and other communicable diseases – particularly those affecting children under five.

Malaria Consortium works in Africa and Southeast Asia with communities, government and non-government agencies, academic institutions, and local and international organisations, to ensure good evidence supports delivery of effective services.

Areas of expertise include disease prevention, diagnosis and treatment; disease control and elimination; health systems strengthening, research, monitoring and evaluation, behaviour change communication, and national and international advocacy.

An area of particular focus for the organisation is community level healthcare delivery, particularly through integrated case management. This is a community based child survival strategy which aims to deliver life-saving interventions for common childhood diseases where access to health facilities and services are limited or non-existent. It involves building capacity and support for community level health workers to be able to recognise, diagnose, treat and refer children under five suffering from the three most common childhood killers: pneumonia, diarrhoea and malaria. In South Sudan, this also involves programmes to manage malnutrition.

Malaria Consortium also supports efforts to combat neglected tropical diseases and is seeking to integrate NTD management with initiatives for malaria and other infectious diseases.

With 95 percent of Malaria Consortium staff working in malaria endemic areas, the organisation's local insight and practical tools gives it the agility to respond to critical challenges quickly and effectively. Supporters include international donors, national governments and foundations. In terms of its work, Malaria Consortium focuses on areas with a high incidence of malaria and communicable diseases for high impact among those people most vulnerable to these diseases.

www.malariaconsortium.org

A CHW trained in ICCM gives anti-malaria drugs to a mother, explaining the dosage and the importance of finishing the course, Samfya, Zambia
Photo: Inzy / Malaria Consortium





REFERENCES AND FURTHER READING

Communication for Social Change: An Integrated Model for Measuring the Process and Its Outcomes. By Maria Elena Figueroa, D. Lawrence Kincaid, Manju Rani, Gary Lewis. The Communication for Social Change Working Paper Series: No.1, 2002 The Rockefeller Foundation and Johns Hopkins University Center for Communication Programs. <http://www.communicationforsocialchange.org/publications-resources?itemid=17>

Community Acceptability and Adoption of Integrated Community Case Management in Uganda. By Nanyonjo A, Nakirunda M, Makumbi F, Tomson G, Källander K, the inSCALE Study Group. *Am J Trop Med Hyg* 2012, In Press.

Community participation: lessons for maternal, newborn, and child health. By Mikey Rosato, Glenn Laverack, Lisa Howard Grabman, Prasanta Tripathy, Nirmala Nair, Charles Mwansambo, Kishwar Azad, Joanna Morrison, Zulfi qar Bhutta, Henry Perry, Susan Rifk in, Anthony Costello, *Lancet* September 2008; 372: 962–71.

Lessons from community participation in health programmes: a review of the post Alma-Ata experience. By Rifkin SB. 2009. *Journal of International Health* 1, 31–36

Malaria Community Competence: A Midterm Evaluation of the Malaria Community Competence Process In Nine African Countries. By PATH for Roll Back Malaria, March 2009.

Accessed at: <http://www.communitylifecompetence.org/en/pages/8-community-life-competence-process>

Midterm evaluation of comprehensive malaria control and integrated community based case management with respect to child survival and health in Western Uganda. By Namara G, Ssekitooleeko J, Nuwa A, Altaras R, Tibenderana J, Killian A, Counihan H; Malaria Consortium, May 2012

Malaria Consortium

Development House
56-64 Leonard Street
London EC2A 4LT
United Kingdom

Tel: +44 (0)20 7549 0210

Email: info@malariaconsortium.org

www.malariaconsortium.org



This material has been funded by UK aid from the UK Government, however the views expressed do not necessarily reflect the UK Government's official policies

Designed & produced by
ACW, London, UK
www.acw.uk.com
October, 2012