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A qualitative assessment of community health committees' participation, with and without community dialogues intervention

Province of Inhambane, Mozambique

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Background

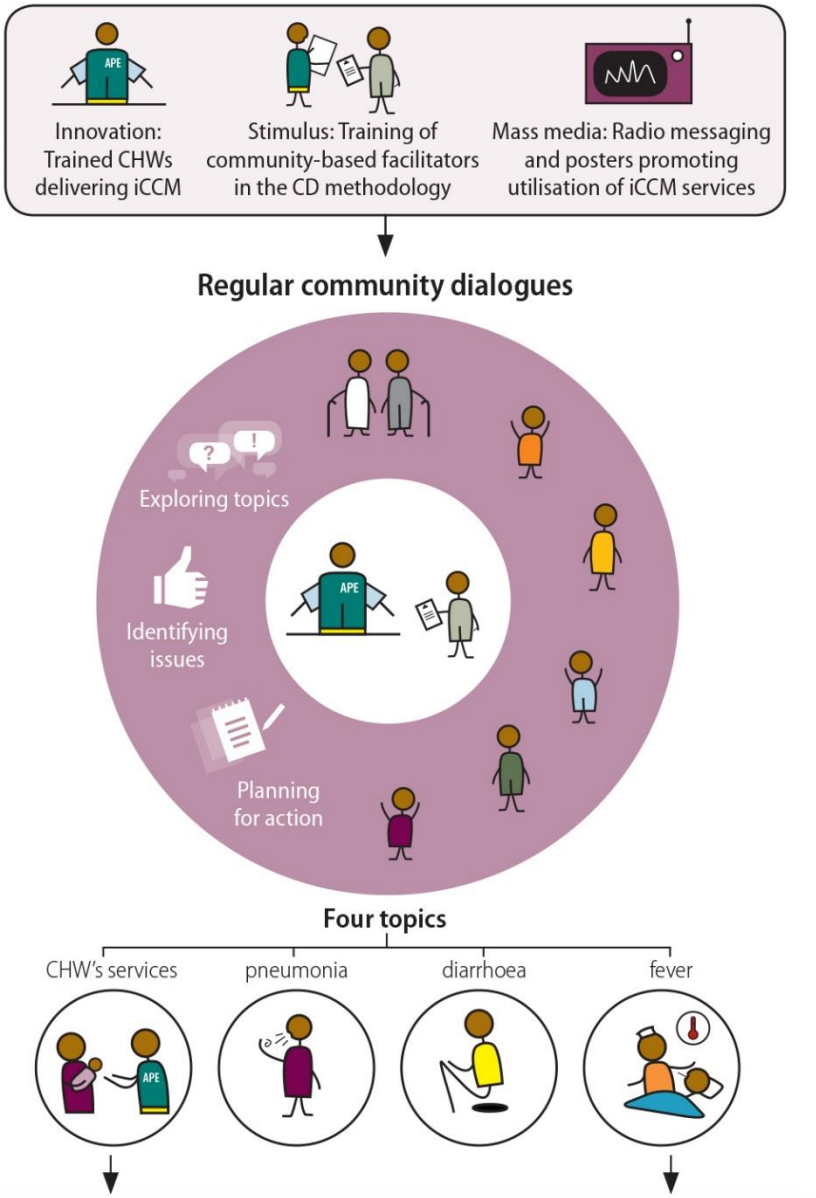
Countries are increasingly adopting the integrated community case management of childhood illnesses (iCCM) strategy in an effort to reduce child mortality.

Community engagement required for iCCM to be successful:

- Individual level- improved care seeking and prevention behaviours
- Social level- new social norms around childhood illnesses management
- Community ownership of services linked to increase performance of CHWs

- No ‘ready to use’ model to effect these changes
- Further research needed, particularly on process (Rosato et al. 2008)

- Design a specific community mobilisation model for Mozambique, CHW-iCCM Programme



Intervention description

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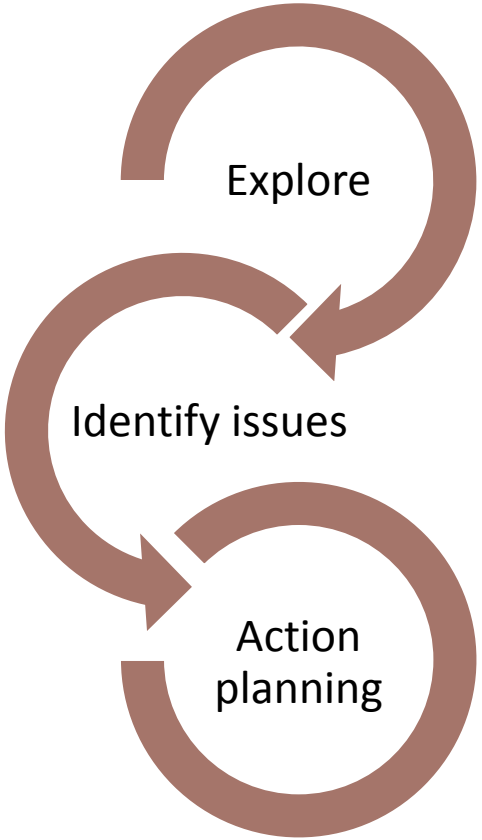
A specific ‘community dialogue’ approach (CD)

- No external facilitation, this is different for other community dialogue models.
- CDs are planned and led autonomously by a group of volunteers from existing local Community Health Committee (CHC).
- Two-day training on participatory facilitation skills and visual tools
- 10 steps for each dialogue from preparation to action planning. Three key processes during the dialogue itself.
- Introduced in CHCs in 7 out of 13 districts in Inhambane province, (Dec-15 to Dec-17) Mozambique.



- Based on the Integrative Model of Communication for Social Change (Figueroa et al., 2002)
- Informed by formative researches: need to go beyond messaging

Guidebook: a simple 10 step process

10 PASSOS para conduzir um diálogo comunitário

TOMAR DECISÕES

1. Assegurar a participação de um APE no Diálogo Comunitário para responder às perguntas sobre saúde.
   Ler o seu Guião de Diálogo Comunitário e o Album Seriado que podem ser usadas para estimular a discussão.

2. Falar com líderes, membros influentes e membros do Comité de Saúde que podem ajudar na organização e condução do diálogo.

3. Marcar a data, hora, tema, tópico e o local de encontro com todos os participantes.

NO DIA DO DIÁLOGO

4. Introdução: Depois do cumprimento dos participantes, apresentar o tema e o objectivo do diálogo. Poderia usar uma canção ou história de interesse de todos, para abrir o diálogo duma maneira motivadora.

Explorar

5. Estimule um debate, deixando as pessoas a partilhar os seus conhecimentos e experiências pessoais sobre o tema, usando exemplos de perguntas no seu Guião de Dialogo, e mostrando o Album Seriado.

Pedir a algumas pessoas para descreverem o que vêem no Album Seriado e mostrá-lo ao grupo. Depois, pedir aos participantes para debaterem. Antes de passar para a página seguinte do album seriado, confirme se foram discutidas todas as informações anteriores. Perguntar se todos entendem as frases, e clarificar se for necessário.

Identificar Acções

6. Em seguida, pedir aos participantes para reportar sobre acções que eles concordaram em fazer no último diálogo, e discutir como ultrapassar as dificuldades.

   Pedir aos participantes que sugiram maneiras de trabalhar em conjunto para resolver o(s) problema(s) identificado (s).

Tomar decisões

7. Os participantes devem concordar com os passos de acção: Quem é que vai fazer o quê? Quando? Como?

8. Resumir as informações e pontos de discussão importantes. Lembrar a todos as decisões tomadas.

9. Agradecer aos participantes por terem partilhado as suas opiniões e marcar o próximo encontro .

APÓS O DIÁLOGO

10. Preencher a ficha de planificação e seguimento.

Guidebook: thematic discussions

Como se trata?

- Levar imediatamente a criança ao APE mais próximo, quando a criança estiver com febre ou alguns desses sinais para ser testado.
- Nem toda a febre é malária; o teste permite que o APE ou profissional de saúde trate o seu filho de acordo com o resultado.
- Completar rigorosamente o tratamento recomendado.
- Uma criança com malária deve acabar com os medicamentos receitados, mesmo se a febre desaparecer rapidamente. Se a criança doente não acaba com os medicamentos, a malária vai ficar no seu corpo e pode voltar mais grave e pode levar are a morte da criança. ①
- Amamentar a sua criança mais vezes que o normal de dia e de noite. ②
- O leite materno é o melhor alimento para qualquer criança doente.
- Voltar ao APE ou à Unidade Sanitária no dia marcado para acompanhamento.

Como se previne a malária?

- Deixar as crianças dormir debaixo da Rede Mosquiteira todas as noites para evitar picada do mosquito que causa a malária. ③
- A Rede Mosquiteira Tratada com Insecticida de Longa Duração é melhor porque afugenta os mosquitos que circulam por perto da rede e mata os que tocam nela.
- Dar à criança de comer e de beber muitos líquidos em pequenas quantidades, mas várias vezes por dia, para recuperar a força.

Evaluation methodology

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Methods

Objective:

Assess the degree of community participation, comparing communities where CHC were trained in the CD approach and where communities did not receive the CD intervention.

Study design:

Qualitative assessment of six dimensions of community participation:
(1) leadership, (2) management, (3) organization, (4) needs assessment, (5) resource mobilisation and (6) implementation of actions, results and monitoring

Limitations:

Small sample size, self-report by respondents and no objective verification of participant's perceptions

Data set

- 4 purposively sampled communities across 2 districts
- 12 focus group discussions
- 5 in-depth individual interviews
- Respondents: community members, members of the CHC, health service providers at health centres and at district office level

Six dimensions of community participation

Dimension	Definition
(1) Leadership	Leadership structure and decision making mechanisms: inclusiveness, information and participation of wider community
(2) Management	CHC's management structure and governance mechanisms, including planning and monitoring mechanisms
(3) Organization	Community organising, including coordination and collaboration between existing community structures
(4) Needs assessment	Capacity to identify local problems and needs, inclusiveness of this process with wider community members and community health frontline workers
(5) Resource mobilization	Capacity to mobilise internal and external resources to solve problems and implement solutions identified
(6) Implementation of actions, results and monitoring	Community capacity to effectively implement decisions made and action plans drawn, including monitoring, towards solving identified problems

Adapted from Baatiema et al., 2013: A sixth dimension, 'Implementation of actions, results and monitoring', was added to Baatiema framework in order to provide a link between the participation process and its results.

Results

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CHCs trained in CD reached higher degrees of community participation

	(1) Leadership	(2) Management	(3) Organization	(4) Needs Assessment	(5) Resource Mobilisation	(6) Implementation of actions
CHC 1 WITH CD	Good	Acceptable	Good	Good	Good	Good
CHC2 WITH CD	Good	Acceptable	Good	Good	Good	Good
CHC3 without CD	Acceptable	Acceptable	Acceptable	Acceptable	Good	Good
CHC4 without CD	Acceptable	Limited	Acceptable	Limited	Acceptable	Good

**Communities where CHCs were trained in CD reached higher degrees of community participation than the communities not trained in CDs*

Improved dimensions

CHCs with CD intervention showed significantly higher performance in three of the six dimensions.

Leadership (1) - significantly more inclusive and participatory, with community members feeling part of the decision-making process

Organisation (3) - demonstrated coordination with other community structures (primary schools, traditional birth attendants)

Needs assessment (4) and problem solving - CD intervention was key for inclusive and participatory assessment

Dialogue outcomes

CHCs with CD intervention also proved more efficient in identifying viable solutions relevant to local context, 6th dimension ‘implementation of actions’.

Specifically, the CD approach allowed for:

Dissemination of information and decisions taken within the CD to the wider community

Most action points were taken as ‘community commitments’ were transformed into community norms

Varied monitoring mechanisms, from solidarity-based approaches (neighbourhood groups) to coercive measures (penalties for non-compliance)

Need for strengthening governance & accountability mechanisms

- All CHCs demonstrated better capacity at endline compared to 2013 baseline
- In all four CHCs, capacity in management (2) and resource mobilisation (5) appear to be problematic
- The lack of opportunities for CHCs to interact and have dialogues with health services was also felt by community members as a recurrent barrier

Lack of transparency on CHC's structure and functioning

Lack of engagement of wider community in CHC management

CHCs mobilise internal human and material resources

Financial contributions are rare

Communities without CD intervention frequently reported difficulties with community mobilisation

Discussion

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Key messages

- CD helps CHCs better fulfil their role. It fills a gap in reaching out to rural communities with basic health information.
- CD makes health promotion activities more participatory and effective in addressing social norms. Agreeing and committing in public is a key facilitator for setting new social norms and effecting individual and collective changes.
- CD approach would benefit from complementary social accountability mechanisms at health facility level. CHCs need support in resource mobilisation and effective integration of community priorities into health programming.

References

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Resources

- ‘Community Dialogue’ model description (Learning Paper, English & Portuguese)
- Process evaluation results (Journal article, English)
- ‘Community Dialogue’ visual materials and toolkits available at http://ccmcentral.com and http://www.thehealthcompass.org
- Application of the ‘Community Dialogue’ model to neglected tropical diseases (operational research)

Thank you

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http://www.who.int/malaria/areas/rapid_access_expansion_2015/en/