



**malaria
consortium**
disease control, better health

Community dialogues for prevention and control of neglected tropical diseases in Mozambique

Sandrine Martin (1), Christian Rassi (1), Ercílio Jive (2), Junica Alface (1), Ossufo Age (2), Marilia Massangaie (2)

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(1) Malaria Consortium, (2), Ministry of Health

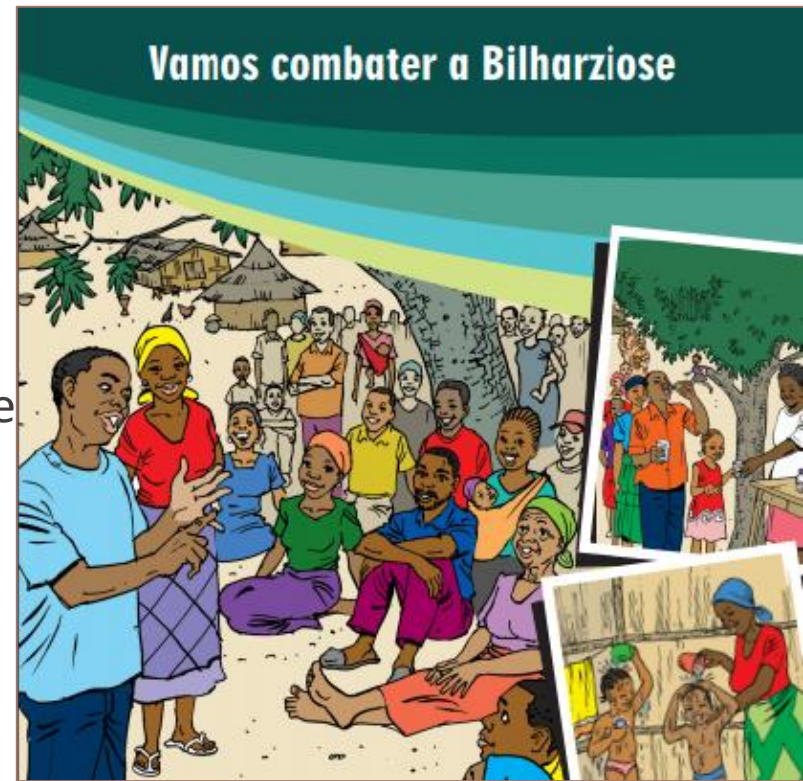
Neglected Tropical Diseases

Social determinants of diseases' burden & control are often neglected



NTDs control & prevention

- NTDs control focuses on reducing disease through periodic, large-scale population treatment ('mass drug administration')
- Adopting early care-seeking & protective behaviours can also reduce transmission: e.g. for schistosomiasis: avoiding contact with infested water, improved sanitation; for LF: use of bed nets.
- A prerequisite for both prevention and control is that communities have an understanding of the disease and what local solutions are available for its prevention and control.



Community engagement

- Health interventions can fail because communities do not understand their need or rationale, leading to poor uptake of recommended practices.
- Community engagement strategies address this challenge by enabling communities to take ownership of health issues.
- In resource poor settings, community engagement approaches need to be practical and feasible.



Enhancing community participation in NTDs prevention & control, Northern Mozambique

Northern Mozambique, Nampula province: the worst affected by NTDs, with high co-endemicity of schistosomiasis, LF and STH

Community Dialogues intervention tested and initiated in the context of NTDs in 2014 in 4 districts

The most populated province of the country (1/5 of total country pop).

Total population of 4 districts: 708,000

Across about 600 communities, mainly rural

Purpose: enhance community understanding of NTDs and participation in local prevention and control efforts



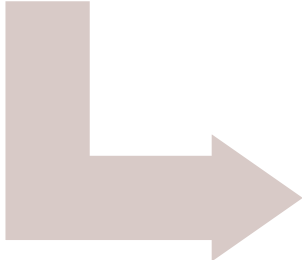
Map of Mozambique, and Nampula province

From operational research to Province-lead model

Operational Research- 4 districts, Schisto

- 2014-2015
- BMGF + COMDIS-HSD
- 160 CDF, but no reliable data on actual pop outreach

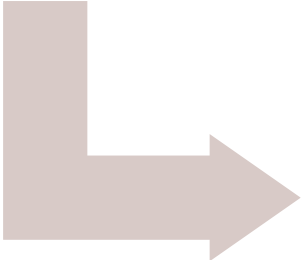
Evaluation: Acceptability, Feasibility, Impact on KAP



2 districts, LF only

- 2016
- Liverpool Centre for NTDs
- No new CDF enrolled

Evaluation: Impact on MDA uptake

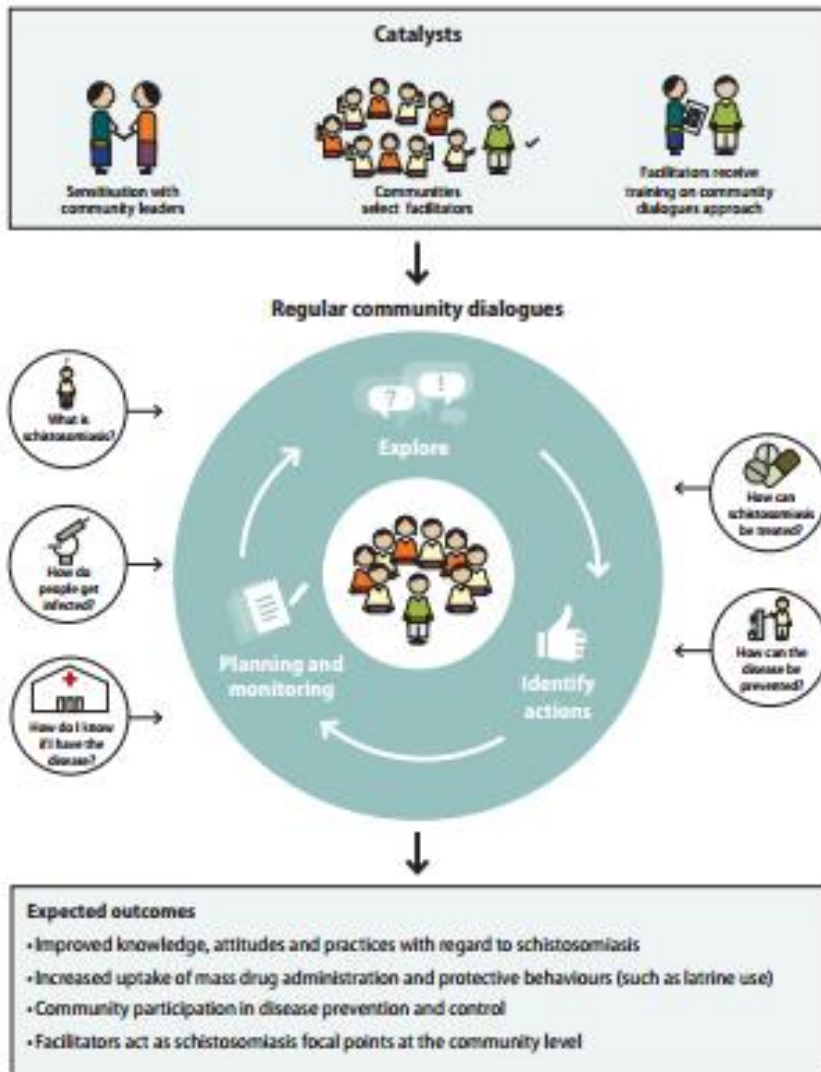


Prov-lead – 4 districts, 3 NTDs (Schisto, LF, STH)

- April 2017- March 2019, BMGF
- 228 CDF, 50% communities

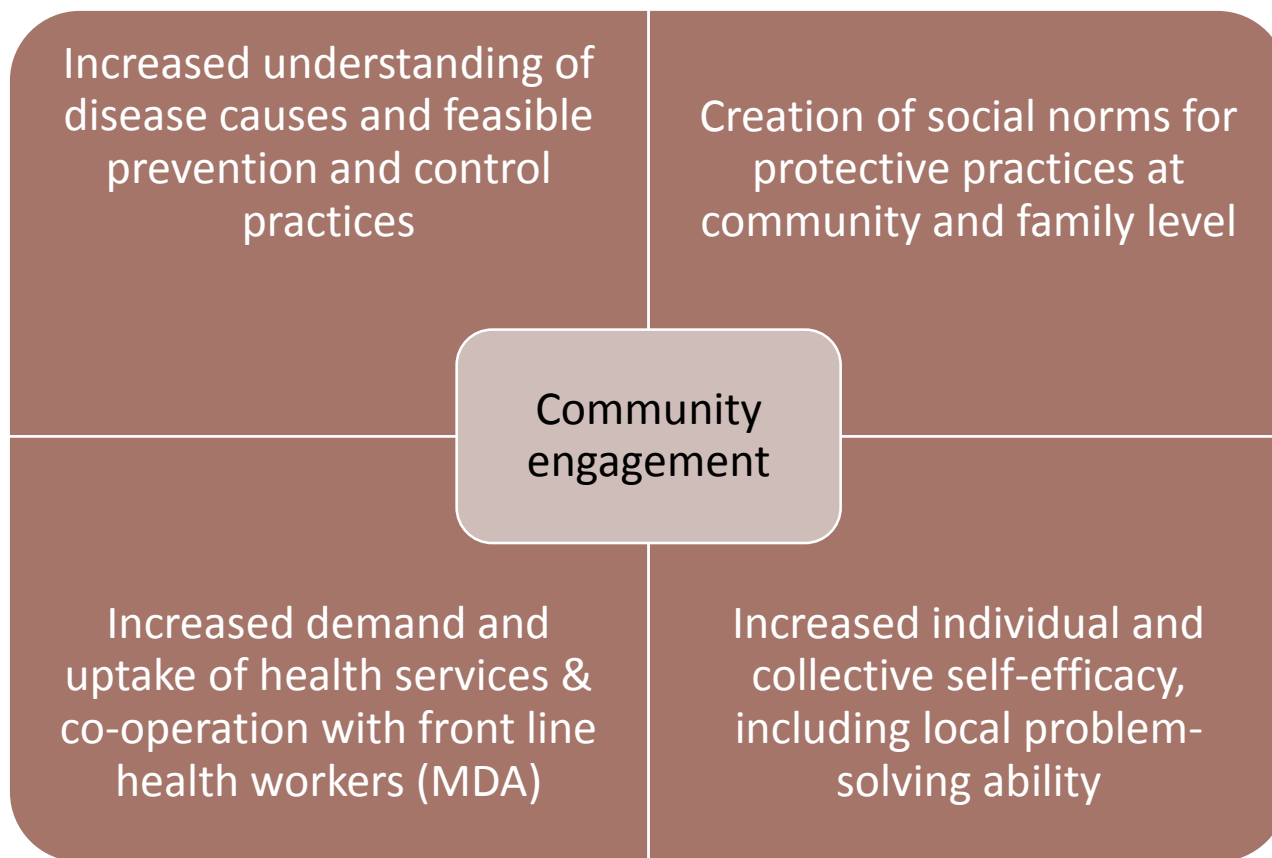


Intervention description



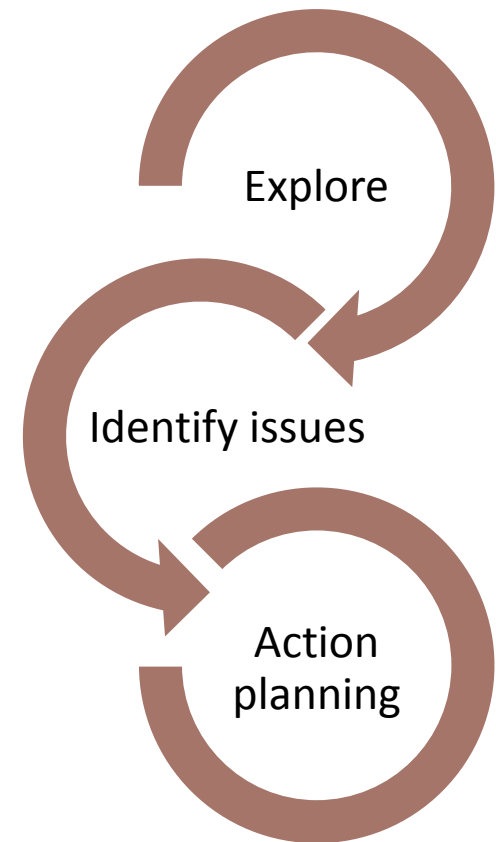
The community dialogues model

Objectives



Community Dialogue

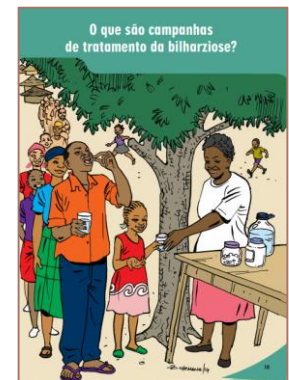
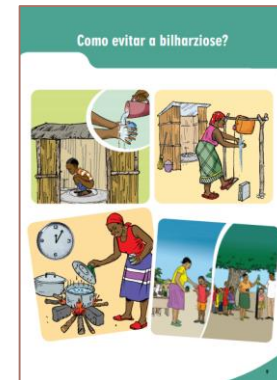
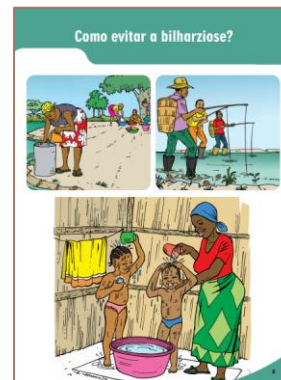
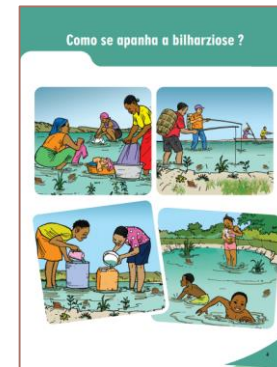
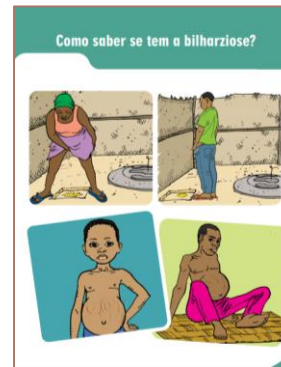
- 3 days training of non-specialist, unpaid home-community volunteers ('facilitators') on a health issue and participatory facilitation techniques
- No external facilitation: local community volunteers conduct autonomously regular dialogues in their communities
- Visual tools designed to stimulate discussions among the community. Moving away from images of extreme cases and focus on risk behaviours VS doable protective practices
- Simple 10-steps process 10 steps incl. 3 key phases during each dialogue
- Embedded within the community structures



3 essential phases of the discussion during each dialogue

Visual toolkit

- **Flipchart:** images designed to stimulate discussion about causes and symptoms of diseases, focus on risk vs protective behaviours.
- 1 flipchart per disease (schistosomiasis, lymphatic filariasis, soil transmitted helminths)
- **Guidebook:** provides facilitators with relevant information relating to the images on the flipchart, as well as tips for mobilising participants and facilitating participatory discussions, and community dialogue scripts.



Samples from Schistosomiasis flipchart

First time that behaviour change communication materials were developed for NTDs in Mozambique

Operational Research phase – Evaluation Methods (2016)

Convergent mixed-methods approach, pre and post intervention

Table 1: Evaluation data collection activities, data sources and focus

Data collection activity	Data source(s)	Evaluation focus
Focus groups	<ul style="list-style-type: none"> Facilitators (n=8) Participants (n=12) Community leaders (n=2) 	<ul style="list-style-type: none"> Feasibility and acceptability Knowledge, attitudes and practices Community participation
Observation visits	Researcher's observation notes (n=11)	<ul style="list-style-type: none"> Feasibility and acceptability Knowledge, attitudes and practices Community participation
Routine M&E	<ul style="list-style-type: none"> M&E forms completed by facilitators for each dialogue (n=1,458) Planning sheets completed by facilitators during each cycle (n=152) 	<ul style="list-style-type: none"> Feasibility Community engagement
Household surveys	Representative sample of households in study districts (n=1,583) at baseline (2014) and endline (2015)	Knowledge, attitudes and practices (population level)

Results: feasibility

- Most facilitators remained active throughout the intervention period; only 9 (/156) did not interact with project staff after the training.
- Facilitators conducted dialogues in 40 of the 68 (59%) administrative units in the four districts.
- Coverage was high in three of the four districts (77-100%), but low in one district (31%). Differing local concepts of 'community' were a major challenge to achieving high coverage.
- On average, approx. 30 dialogues were conducted per administrative unit (15months - July 2014 to October 2015)



Results: acceptability

- Facilitators enjoyed their role and, in particular, appreciated being agents of change within their own communities.
- Participants generally found the dialogues useful and valued their interactive and inclusive nature.
- The toolkit was very well received by both facilitators and participants.
- The main criticism was that the project did not provide resources (boots, medicines) and was not linked to mass drug administration campaigns.

“I was interested not for personal gain, but because I explained to the community how to prevent a disease. And then people say, ‘What you explained is having a positive effect on the community.’ So it’s satisfying.”

- Focus group with facilitators

“Everyone had the opportunity to speak, no one felt excluded. This is not a party political meeting. The disease affects us all, so all of us talked about it.”

- Focus group with participants

Results: knowledge, attitudes and practices

- Facilitators and participants showed a good level of knowledge.
- Occasionally, knowledge was not bio-medically accurate, while still relating to generally positive behaviours (e.g. hand washing as a protective behaviour for schistosomiasis).
- Many facilitators and participants reported that behaviour in the community had changed as a result of the dialogues, e.g. construction of latrines.

“We discussed how we can prevent contracting this disease. We explained that people get it from microbes that live in snails and are invisible to the naked eye.”

- Focus group with participants

“The facilitators talked about hygiene [...] We mustn't wash our hands without soap.”

- Focus group with participants

Results: knowledge, attitudes and practices

At population level, there was some improvement with regard to correct knowledge. However, misconceptions persisted and uptake of protective behaviours did not improve significantly between baseline and endline.

Table 2: Key knowledge, attitudes and practices indicators from baseline and endline household surveys

Indicator	Baseline % (95% CI)	Endline % (95% CI)	Wald P-value
Heard of schistosomiasis	91.96 (89.51-93.89)	91.28 (88.17-93.63)	0.52
Names at least one correct risk behaviour	18.02 (14.63-21.98)	30.11 (25.05-35.71)	<0.01**
Names at least two effective prevention or treatment mechanisms	12.83 (9.69-16.80)	15.28 (11.69-19.72)	0.57
Knows there is a drug that treats the disease	29.20 (24.72-34.13)	47.55 (43.38-51.75)	<0.01**
At least one child in household received praziquantel	9.33 (6.69-12.86)	15.10 (11.30-19.89)	0.01**
Practices at least one effective protective behaviour	40.09 (32.59-48.09)	59.30 (50.83-67.26)	<0.01**

Results: community participation

- Facilitators reported that they had strong support from community leaders/structures in mobilising participants.
- Participation was generally high, with average numbers of participants between 20 and 40 per dialogue.
- Several communities reported taking communal action, e.g. supporting construction of latrines.
- However, the planning step was frequently not well executed and responsibility for implementing decisions remained vague.

“After the decision [to build latrines] was made, I had help from the local authority. We formed a ‘community police’ to make sure that people no longer practiced open defecation.”

- Focus group with facilitators





Implications

- Community dialogues are a **feasible** approach. The main challenge is achieving high coverage and determining the coverage level required for achieving impact at population level.
- Community dialogues are **acceptable** and well-received by facilitators and participants. In order to increase acceptability, they should be closely linked with existing health structures and mass drug administration campaigns.
- There are indications that community dialogues contribute to **increasing knowledge and adoption of protective behaviours**. A more integrated approach including diseases requiring similar behaviour changes should be considered.
- Community dialogues also appear to contribute towards **increasing community participation**. However, the planning step needs to be strengthened to better enable communities to take communal action.

Refining the approach with stakeholders

2018

19

- Coverage for impact  Prioritization of most remote and vulnerable communities: training of 230 facilitators
- Timing with MDAs  CD facilitators involved in MDA social mobilization & CD topics aligned with MDA
- Integration with other diseases  3 NTDs: schistosomiasis, lymphatic filariasis, soil transmitted helminths
- Strengthen action taking step  Embed facilitators in local Community Health Committee (where exist)

Lessons learnt

Implementation April 2018 – Feb 2019
Evaluation Feb-March 2019

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- Very low attrition of volunteers: motivated to continue even without project support; become role model of protective practices in their home
- But Tendency of facilitators to resort to didactic health talks instead of participatory discussion: they see themselves and are seen by community as “health sector” resource person and mimic health workers
- Social Diffusion: information shared at CD passed on to wider community; most action points taken as ‘community commitments’ being transformed into community norms
- Persistence of misconceptions, while knowledge increases: different beliefs systems co-exist
- Communities often feel they do not have the capacity and resources to prevent, treat and control effectively NTDs – need support in trying out local feasible solutions
- Challenges in implementation of MDAs (shortage of drugs, planning and delivery issues) leading to missing out on communities, despite demand being created.
- Opportunity for blending the approach with others such as edutainment and school clubs.

Key messages

- Community dialogues are a promising approach to address some of the socio-cultural determinants for NTDs prevention and control.
 - CDs fill a gap in reaching out to rural communities with information and correcting misconceptions
 - Agreeing and committing in public is a key facilitator for triggering individual and collective changes in protective practices
 - CDs can increase uptake of available preventive and curative services
- There needs to be complementary integrated programming addressing the environmental factors, e.g. access to water and sanitation, to enable communities to apply effectively protective behaviours.
- Community dialogues are practical in resource-poor settings, because they use community volunteers and require little investment beyond the development of materials and training.
- Increased interest in addressing social determinants of NTDs needs to be matched with resources: high interest for the CD approach at Health Promotion and NTDs departments (MoH) and province/district levels, but lack of resources (funding) to act on embedding the approach into policy and strategy

More Information

More on this approach

<https://www.malariaconsortium.org/projects/comdis-hsd/23/community-dialogues-for-prevention-and-control-of-neglected-tropical-diseases>

Community Dialogue implementation guide

<https://www.malariaconsortium.org/resources/publications/1185/a-guide-to-implementing-the-community-dialogue-approach>

Journal article

<https://www.malariaconsortium.org/resources/publications/990/community-dialogues-for-child-health-results-from-a-qualitative-process-evaluation-in-three-countries>

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Thank you.

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