malaria consortium

disease control, better health

A guide to implementing the

Community Dialogue Approach

Contents

Part one: An introduction to the Community Dialogue Approach 4

Background 5
What is the Community Dialogue Approach? 6
When is it appropriate to use the Community Dialogue Approach? 7
How does the Community Dialogue Approach work? 8
What happens during a Community Dialogue Approach session? 9
Where has the Community Dialogue Approach been used before? 10
How does the Community Dialogue Approach compare to other approaches? 11
What are the core principles of the Community Dialogue Approach? 12
1. Grounded in theory and context 12
2. Embedded within existing structures 12
3. Social Accountability 14
What are the key assumptions of the Community Dialogue Approach? 16
What resources are required to implement the Community Dialogue Approach? 18
How is the Community Dialogue Approach implemented? 19
What are the potential limitations of the Community Dialogue Approach? 20

Part two: Things to think about 22

Phase I: Programme inception and design 24
1. Conduct a situational analysis 26
2. Develop research protocol 27
3. Conduct formative research 29
4. Prepare draft design and implementation strategy 29
5. Hold consultative stakeholder meetings and design workshops 29
Phase II: Pre-implementation 36
6. Conduct courtesy visits 36
7. Conduct baseline survey 37
8. Recruit and register volunteer facilitators 37
9. Conduct training of trainers 37
Phase III: Implementation 38
10. Train volunteers 38
11. Report and monitor 38
12. Support, supervise and act on feedback 39
Phase IV: Post-implementation 41
13. Evaluate Impact 41
14. Share experience and findings 41

References 42

Acknowledgements 43

What is the purpose of this guide?

This guide is intended for health programme implementers who want to help communities make healthy choices. It introduces the Community Dialogue Approach, an innovative and participatory approach used to help achieve and sustain social action towards improving the health of communities. The approach could be considered both a community engagement and social and behaviour change intervention.

The focus of Part One of this guide is to help health programme implementers decide whether the Community Dialogue Approach is appropriate and will be effective in helping them to achieve their programme objectives. Part One explains the approach's theoretical underpinnings, and shares experiences from successful implementation, as well as its limitations. By the end of Part One, prospective implementers should understand what is involved in the approach and be able to determine whether or not it is right for them.

In Part Two, steps are provided in order to contextualise the approach for specific health or behavioural outcomes. As it is well recognised that participation in design, evaluation and research improves the likelihood of success,[1] Part Two provides guidance to implementers on how and when to effectively engage stakeholders from national, sub-national and community level, during design, implementation and evaluation. Guidance is also provided in order to develop the requisite material to support implementation. For training purposes the guide will refer to tested manuals used in prior implementation.

The Community Dialogue Approach has been successfully implemented in a variety of low-resource settings and hard to reach communities. It has been proven to increase knowledge, promote protective health behaviours and improve the uptake of health services. The approach provides a platform for learning about targeted health topics and developing consensus for how best to manage these as a community. It uses structured and participatory communication in order to support the production of plans of action while positively influencing social norms and individual behaviour.

Disclaimer: the Community Dialogue Approach will be most impactful when full participation is achieved and communities genuinely own the platform. Interested readers should be open to relinquishing creative power and focus of the topics to be explored, and potential solutions which may be put forward by participants in order to remain true to the approach.

1

Part one: An introduction to the Community Dialogue Approach

Background

There are multiple factors responsible for health inequities. These are referred to as the social determinants of health and are the conditions in which people are born, grow, live, work and age.[2] These forces include economic policies and systems, development agendas, social norms, social policies and political systems.[2] While it is not possible to address all of these factors through social and behaviour change, it is possible to influence social norms which play a role in influencing individual behaviour. People, both rich and poor, sometimes make choices that do not promote their own well-being.[3] This can happen even after careful deliberation when thinking automatically.[3] "Automatic thinking means not bringing to bear full knowledge about the dimensions and consequences of choices. People may also get stuck in habits, succumb to inertia, and repeatedly procrastinate despite intentions to do otherwise".[3]

Implementers of health interventions often face challenges when providing or extending services to the hard-to-reach and most affected populations. These challenges include achieving optimal coverage (reach), acceptability (uptake) by communities, and/or a lack of resources to sustain solutions. Diseases are often unknown and misunderstood, resulting in risky or harmful behaviours or suboptimal health seeking behaviours. Implementers from outside the community are often met with hesitation, where the information and advice they provide is not accepted or readily adopted by communities. This can be due to interventions being designed from the perspective of healthcare providers, and not adequately taking into consideration factors at the community level, including local understanding, beliefs and practices, as well as how local resources can be utilised better. The Community Dialogue Approach was developed with these challenges in mind.

Solutions to health issues often exist within communities. The elimination of the root causes of disease requires positive action to be taken by community members to change their social norms and patterns of behaviour from ones promoting sickness to those promoting wellness.[4] In order to do this, an individual needs knowledge and awareness of the diseases, as well as an understanding of their role in protecting themselves, their families and their communities, and the motivation to take action and develop habits which become ordinary parts of their daily lives. The Community Dialogue Approach can help communities to achieve this by facilitating meaningful community engagement and ownership.*

* How to determine appropriate SBC intervention. Available at https://www.thehealthcompass.org/how-to-guides/how-plan-interpersonal-communication-intervention

What is the Community Dialogue Approach?

The overall objective of the Community Dialogue Approach is to contribute to triggering individual and social change in communities for improved health outcomes. This is accomplished through meaningful community engagement: a collaboration with community-based structures and healthcare systems. The Community Dialogue Approach uses a participatory approach to establish a platform where communities can explore salient health issues and identify potential solutions most appropriate to them.

In order to strengthen the working relationship between the community and the health system, the Community Dialogue Approach establishes linkages. These linkages are made primarily by including government health staff in the Community Dialogue Approach through their responsibilities in supervision and reporting. The designated focal points are trained and carry out joint supportive supervision.

As the Community Dialogue Approach promotes not only healthy behaviours, but also the demand for services and products by the community, it is important that the supply side is aligned. The strong linkage with the healthcare system helps to ensure technical oversight and strengthens referrals for diagnosis and treatment of health conditions to the appropriate health service. Through meaningful participation in Community Dialogue Approach sessions, health providers also help to develop trust and accountability for the delivery of health products and services, while not interfering with the volunteer's facilitation of the Community Dialogue Approach sessions.

During Community Dialogue Approach sessions communities are also encouraged to explore the possibility of leveraging existing resources in the community in order to find solutions for the issues identified during the Community Dialogue Approach sessions.

Implementers of the Community Dialogue Approach can choose to introduce specific health topics, or encourage broader exploration of common concerns related to health led by communities themselves with guidance from trained community based facilitator volunteers (hereafter referred to as volunteers). The topics can be guided through close collaboration with health facility staff.

It should be noted that this approach does recognise that there are external factors that are outside the influence of the community, which can either inhibit or enhance the impact of the Community Dialogue Approach.[5] However, guidance is provided on how best communities can acknowledge these and focus on the issues that they have the power to influence and change.

The Community Dialogue Approach is deliberately participatory and action oriented. The approach builds upon the existing capacity of the community to address local issues by making informed decisions and encouraging collective action to bring about social change for improved health outcomes. The intent is to establish a degree of ownership over the intervention, and empowerment over improving one's own health, the health of their family and health of the community to which one belongs. Designed in this way, the platform can be self-sustaining and can be used by communities beyond the lifespan of the programme.

When is it appropriate to use the approach?

The Community Dialogue Approach should be considered for community engagement and social and behaviour change when the health issues intended to be addressed by programmes are being influenced by behavioural factors and when the likely factors contributing to or inhibiting the behaviour in question are strongly influenced by awareness, social norms and other community factors.[5] Careful consideration should be given to understanding what the possible behaviours are that the community can adopt which can realistically make an impact on their health. In order to adopt a behaviour, an individual must have the capability, motivation and opportunity. [6] Over time, with repetition, this behaviour can become a habit.

Understanding these factors will also be important for developing the theory of change and community profiling exercise.*

The Community Dialogue Approach can be initiated with a specific health topic in mind, and once the community has established the practice of conducting regular Community Dialogue Approach sessions, successfully implemented the plans of action, and benefits to communities are apparent, it may continue to be used by the community to address additional salient issues beyond those initially proposed by the intervention.

The approach has been designed specifically for low-resource settings and hard to reach areas as it requires few material inputs and little supervision. It has been designed to support broader health programming in low-resource settings, however it can be easily adapted according to context and need, as well as blended with other SBC techniques such as radio, forum theatre or positive deviance.

In order to determine whether or not the Community Dialogue Approach is appropriate to help achieve programme objectives, ask yourself the following:

- What is the specific behavioural objective or set of specific behaviours your programme is addressing? *Note: refer to your broader health programme objectives.*
- Does this behaviour require inputs that are not available in the community (or that will need to be provided continually)? That is, can the community realistically change their behaviour in order to have an impact?
- Is this specific behaviour influenced by family members, traditional or religious customs, or other social norms at the community or societal level and not by supply-side issues e.g. stock of medicine at the health facility? *Note: it can often be both.*

*How to identify and prioritise behaviours, https://sbccimplementationkits.org/malaria-case-management/lessons/step-1-identify-and-prioritize-behavioral-problems/

How does the Community Dialogue Approach work?

Using communication skills and a stepwise instruction learnt from their training, the facilitators are able to strategically guide discussion. This will help community members reach consensus on what can be done to address the identified issues and by whom, given the locally available resources. Discussion (explore, identify, decide) among the community is stimulated with the help of simple visual tools. The tools contain information about health topics, including prevention, control and treatment, as well as guidance on facilitating the Community Dialogue Approach sessions. Action plans are developed as an output of the Community Dialogue Approach sessions, with specific tasks equitably designated to community members.

The community-based facilitators are trained on health issues and facilitation skills and provided with tools that guide the Community Dialogue Approach sessions. The sessions are held on a regular basis and involve different members and groups within the community. The volunteers select topics based on needs and requests from the community. They guide the discussion through a series of steps which involves exploring, identifying issues and developing plans of action from the decisions taken.

Key to the Community Dialogue Approach is fostering a sense of social accountability within the community. In order to effect lasting change, the community members must be willing to take responsibility for their actions and work with healthcare providers to effectively control, prevent and treat diseases by adopting preventive behaviours and adhering to treatment plans, starting with prompt diagnosis. This collective action relies on consensus of community members in deciding on the action plans as well as social accountability to follow them up.

The Community Dialogue Approach works to establish a strong sense of social accountability wherein stakeholders hold one another to account, whether it be in the delivery of health services, appropriate use of health products, health seeking behaviours, or do-able actions at the household level. Over time these behaviours (public commitments, setting a positive example by undertaking the behaviour, word of mouth, etc.) can lead to changes in social norms and influence the behaviours of others in the community.[7]

Community dialogue gathering, Mozambique

What happens during a Community Dialogue Approach session?

During each session, community members explore a topic, identify and prioritise specific issues and behaviours, and collectively agree on actions and mechanisms for the community to resolve these within their own means and strengths.[7] The community dialogue volunteer guides the session through three steps:

1. **Explore:** volunteers introduce the health topic using the visual aids provided during training. Participants are encouraged to explore the health topic and are prompted using open-ended questions and encouraged to share their personal experience. The visual aids are designed to facilitate this discussion, fill knowledge gaps and correct misconceptions.

2. **Identify:** after reflecting on how the health issue affects them, participants are prompted to reflect critically on positive and negative behaviours relating to the issue. The discussion is guided so that participants exchange perceived successful and unsuccessful coping strategies and can reach a consensus on the causes and solutions to the challenges identified. Participants should propose what they can do more of or differently to help improve the situation. This discussion will result in the development of plans of action which will be carried out by the participants and shape future behaviours, including those of the wider community.

3. **Decide:** participants review actions and behaviours which have been identified as desirable, discussing how they could be applied in the local context. This collective and public decision-making process is expected to result in positioning of locally relevant recommended behaviours as the social norm and lead to planning for communal action. During the Community Dialogue Approach session, participants make public commitments to resolve the health issues through small doable actions. At the beginning of each session, the participants reflect on what had been decided as part of the action plans from the previous session. Participants discuss what was achieved, what has not been achieved and any possible barriers. The participants from the previous session may not all be in attendance, but some usually are.

It should be emphasised that the Community Dialogue Approach is not recommended as a standalone intervention. As with all effective social and behaviour change communication programming, a mix of channels and techniques should be used as appropriate, in order to reach target audiences and the multiple levels in the socio-ecological framework. For example, the Community Dialogue Approach can be complemented by mass media campaigns which could highlight important points gleaned from the Community Dialogue Approach sessions. This process of information triangulation can also help increase the legitimacy of the information.

Furthermore, if products or services will be promoted then health system strengthening supply-side considerations should be made to ensure increased demand for the health services and products can be met.

Where has the Community Dialogue Approach been used before?

Malaria Consortium and partners have implemented the Community Dialogue Approach across a range of health topics and geographic settings as part of broader health strategies. Examples of application include:

- promoting the adoption of the integrated community case management of childhood illnesses in Mozambique, Uganda and Zambia
- improving prevention and control of neglected tropical diseases at community level in Mozambique, including the uptake of mass drug administration (MDA)
- reducing the inappropriate use of antibiotics among community members in Bangladesh.

The Community Dialogue Approach has also been used to also address a wide range of issues of interest to the community, such as HIV/AIDS, tuberculosis, vaccinations, new-born and child care, rheumatism, ocular trauma, paralysis, tetanus, asthma, family planning, elderly care and control of fires for trash or bush clearing.[7]

Where the Community Dialogue Approach has been implemented, rigorous research has also been applied in order to determine effectiveness and improve future application. The results of these studies have shown that the approach can help to improve the uptake of health services and promote recommended preventive health behaviours.

The Community Dialogue Approach experience has been successful in contexts where a minimum literacy level exists, enabling community-based facilitators to use the existing guide and tools. However, the current approach could be adapted further for non-literate facilitators. The evaluations indicate that it is an effective tool for setting new social norms and moving from information to action through the commitments agreed upon in public.[8]

The approach has been piloted in remote and hard to reach areas, and not in urban settings. Additional research may be necessary to deem the effectiveness of the approach in highly populated and urban settings.[9]

A mapping activity by community members, Zambia

How does the Community Dialogue Approach compare to other approaches?

Although other approaches, such as Village Health Clubs* or support groups such as mothers' clubs, are based on many of the same principles, one of the distinguishing features of the Community Dialogue Approach is its openness in participation. Where other similar behaviour change approaches have a targeted or closed membership, the Community Dialogue Approach is open to all community members as it is designed to impact social norms as well as individual level behaviour. Similarly, these other approaches should also be combined with other SBC techniques such as mass media (radio programming or text messaging).

The Community Dialogue Approach is also flexible with respect to the topics and content covered during a session. Although it can be introduced using a set 'curriculum' on a health topic, the volunteer facilitator can decide to introduce new topics at the request of the community or as the need arises.

* https://www.malariaconsortium.org/resources/publications/628/establishing-village-health-clubs-to-improve-community-health-worker-motivation-and-performance

What are the core principles of the Community Dialogue Approach?

The Community Dialogue Approach was founded on three community engagement principles; grounded in theory and context, community ownership and evidence. When adhered to, these principles can help to ensure intervention fidelity. These principles are also integral to meaningful community engagement.

1. Grounded in theory and context

The Community Dialogue was developed by Malaria Consortium and Consortium de recherche sur les prestations de services de santé liés aux maladies transmissibles (COMDIS-HSD) using SBC theory and models, including the Integrated Model of Communication for Social Change (IMCFSC),[4] and piloted in multiple contexts. The IMCFSC involves an iterative process where communities engage in dialogue to produce collective action and social change.[5] The approach addresses a set of constructs and determinants of behaviours including knowledge, risk perceptions, expectations, self-efficacy and subjective and social norms in order to sustain healthy behaviours within the community.[5] The Community Dialogue shares common assumptions with other participatory learning and action approaches, such as the principles of respecting the community's capacity to address its own problems, seeking out and actively engaging local knowledge and diversity, and a set of processes that enable analysis, sharing and empowerment.[4]

2. Embedded within existing structures

The Community Dialogue Approach is embedded in the healthcare system. Embedding it within the healthcare system helps to strengthen the working relationship between health workers and the community, and improves trust. Strong linkages with the health system are integral for disease management, motivation, and technical oversight. With more frequent and higher quality interactions, communities will have better access to information and be more inclined to approach health service providers with queries or concerns. This can strengthen the overall referral process and help to alleviate the burden of disease. Where coverage or uptake of services is low and health practices are sub-optimal, Community Dialogue facilitators can act as a bridge. In order to ensure full integration into existing local health structures and programmes there must be endorsement from the Ministry of Health. An example of this is joint support supervision visits with health workers during a Community Dialogue Approach session and the district (or subnational level). For example, the district focal point is responsible for reviewing and compiling monthly reports prepared by volunteers and aggregated through the primary healthcare centres.

Community ownership of the platform is also integral to the platform's legitimacy as a source of information and its sustainability. For these reasons the Community Dialogue Approach is both developed in partnership with communities and delivered by community-selected volunteers with support from health workers. Embedding in existing community structures will enable ownership over the process, and increase participation in the design and implementation of the Community Dialogue Approach. Some examples of community structures include local leadership figures and influencers (such as chiefs and elders), women's groups, youth groups, savings groups, and religious groups. In a review of the effectiveness of types of partnerships for health promotion, it was found that 'gains had greater impact and sustainability the larger the community involvement in the practical activities of health promotion'.[4]

Mother and baby attending a community dialogue session, Mozambique

Involving communities in the design and delivery of health services can also help to ensure optimal relevance, coverage, uptake and impact.[10] It was also found that the 'immediate relevance and emotional connection of the focus' was crucial, demonstrating the importance of 'framing initiatives in ways that are meaningful to the targeted group, which can best be done in the context of their daily lives, their social networks, activities, attitudes and meeting places'. [3] This means that to ensure effective community engagement – particularly in areas with high levels of diversity and disparate social contexts – activities must be highly localised. One element of this is the community facilitated selection of appropriate volunteers. If this process is community-led, it is more likely the outcome will be acceptable, the platform will be functional, attendance will be high, and approach sessions will be held regularly.

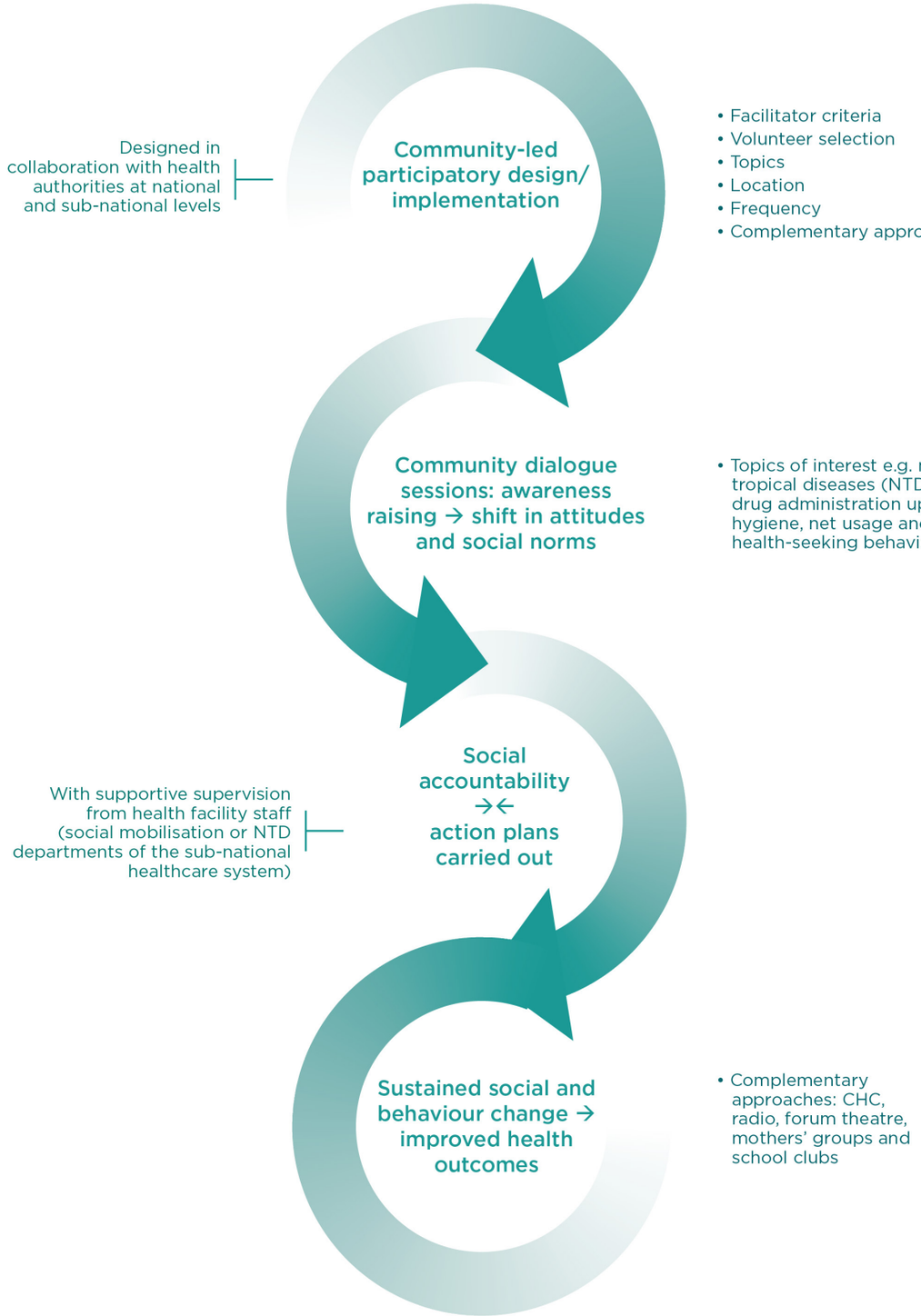
Embedding in community structures starts from the participatory planning stage, and is a precursor to community ownership. The existing structures in which the Community Dialogue Approach can be embedded will depend on the context in which it is being implemented. Embeddedness is important in order to select ideal volunteers who will be responsible for guiding the Community Dialogue Approach sessions and ensuring participation of key influencers and target audiences. This will allow for the Community Dialogue platform to be used to resolve future health issues in the communities where the approach has been established. This also ensures that the platform does not rely on any single volunteer and that the role can be replenished through cross-training and with support from the healthcare system.

3. Social accountability

Social accountability refers to community members taking responsibility for their own health and holding health actors (such as community health workers) to account. The Community Dialogue Approach is designed to foster social accountability by promoting demand for health products and services and increasing trust between the community and the healthcare system. Communities must be informed of the services available to them in order for them to be able to advocate for their right to access information, especially in hard to reach and low-resource settings. During training, volunteers should be briefed on what other informational packages are available from their health facility, and liaise with the in-charge or district focal point should they notice a need or request from the community.

The Community Dialogue Approach accelerates social and collective action by supporting the creation of community-owned plans of action (outputs from the sessions), that are directed towards resolving the issues identified during the 'exploratory' phase. Social accountability is necessary for action plans to be carried out. Service providers are responsible for delivering products, services and advice, (and communicating with communities), while their intended recipients (the community) are responsible for assuming responsibility for their health and associated actions.

Community ownership is also a part of social cohesion necessary for reaching consensus on the issues discussed during the planning step of the Community Dialogue Approach sessions, as well as actually carrying-out the action plans. Since the approach includes three steps, finishing with planning and decision making, it is up to the community to decide how they will ensure they are accountable to their plans of action. This may require creative solutions in order to prompt and remind participants to take action which can also be generated during the 'deciding' step.



Community dialogue participants, Mozambique

What are the key assumptions of the Community Dialogue Approach?

The Community Dialogue Approach is based on a set of assumptions. Though they are assumed, there are steps that programme implementers can take to also ensure the assumptions hold throughout implementation.

Understanding the following assumptions can help to moderate expectations and understand whether or not the Community Dialogue Approach is feasible.

'The community' – Communities are complex and diverse, with many dimensions and power relations. Special consideration must be given to how 'the community' is defined by programme implementers with regards to the selection of volunteers, topics, and participant mobilisation. The outcome of this exercise is most accurate when completed in collaboration with communities themselves. This can be accomplished as part of the formative research and is integral to successful integration and effectiveness. The consideration of all segments, especially marginalized groups, is especially important if the approach is going to be inclusive and effective in raising the voices of the whole community on issues which affect their health and wellbeing.

Volunteerism – The community must be willing to participate in both hosting and attending the Community Dialogue Approach sessions. As this approach is based on volunteerism, it is important to consider the interest and willingness of the community to take on the approach, as well as the availability and capacity of proposed volunteers and participants. Volunteers need to be carefully selected by the community, with clearly defined expectations and criteria to guide them. The ideal volunteers are enthusiastic, committed, and passionate. The volunteer does not need to have experience in health promotion but should have a good relationship with the community and the energy to sustain this activity over time. As part of the planning process, a volunteer management strategy should be instated. This should consider the national guidelines for remuneration of community health workers as well as other partners working in the same, or nearby, areas of implementation. It is also advisable that the health provider focal points oversee the selection of volunteers to ensure all criteria are met.

Health systems strengthening – Health systems strengthening takes places concurrently in order to meet supply side demands for products and services.

Empowerment – It is assumed that over time communities will recognise their agency in determining health outcomes by identifying issues and carrying out plans of action that lead to positive results. This empowerment can contribute to social accountability, where community members are engaged as citizens, demanding access to effective health services and holding each other to account according to their agreed action plans.

Process – Behaviour change is a process. Every community is unique, and the process may be different for different communities. Sometimes a step in the process can be skipped or reordered, and certain aspects of the Community Dialogue Approach can be reversed. According to the trans-theoretical model, in order for behaviour change to be fully realised, a process must take place over a period of time.[11] Implementers and communities should be supported to understand that social norms are complex and social change is not always linear. As such, social change requires long-term commitment and flexibility, and stakeholder expectations should be managed accordingly.

Repetition – Changing attitudes and practices requires frequent discussion and reminders. Habits aren't established overnight. The advantage of using local facilitators is that they are within the community all the time and can provide reminders. Community Dialogue Approach sessions should be held regularly and until the desired behaviour has been adopted, and even beyond, to ensure the behaviour is maintained. This stage can also trigger the introduction of new topics.

Spill-over effect – It is assumed that although only a proportion of the population in a particular community will actively participate in sessions at any one time, the intervention will have wider impact on social norms, knowledge, and attitudes and practices (KAP) at population level through word of mouth, collective decision making, and the setting of positive examples.[8] This has been demonstrated during previous interventions when direct participants reported passing information to other community members, and in a study which showed the impact of the Community Dialogue Approach on population-level knowledge of neglected tropical diseases (NTDs).

What resources are required to implement the Community Dialogue Approach?

Human resources – Staff (implementers) with experience in community engagement and social and behaviour change, and volunteers with good rapport in communities. Volunteer facilitators also need to have sufficient levels of literacy in order to understand and use Community Dialogue tools and undertake reporting. As such, there needs to be sufficient levels of literacy within the communities from which volunteers are chosen. The existing approach and corresponding tools would need to be adapted for use in low literacy settings.

Financial resources – Budget is needed for research (formative, baseline, endline, pre-testing); translations and printing of visual materials; training and refresher training (according to scale of implementation, cascade training may also be required); printing of routine report forms and training manuals; identification material (branded t-shirts, identification cards); coordination meetings; sensitisation meetings and feedback meetings; training; monitoring visits; and dissemination of results.

Government buy-in – For integration into broader health programming and an open mind towards a community led approach to determine what health issues are important to local communities. A good working relationship with the Ministry of Health is needed to ensure buy-in, sustainability, and scalability.

How is the Community Dialogue Approach implemented?

Adapting the Community Dialogue Approach for programmes starts with a series of participatory meetings and buy-in from the government to determine how best the approach can be integrated to support broader health programming. It is entirely up to the country to decide where in the healthcare system the Community Dialogue Approach will be inserted and who needs to be involved in the process, based on the priority health issues that need to be addressed.

Participatory design can help to ensure the Community Dialogue Approach is supported by the correct actors from community level to health facility level and sub-national and national levels. This is necessary to achieve scalability and sustainability.

Key to the approach is a catalyst which prompts participants to identify an issue of concern.[5] Community-based facilitators (to be referred to as volunteers going forward) act as the catalyst. Those who meet the selection criteria are recruited by their communities and trained on health topics and facilitation skills. It is agreed with the volunteers that their responsibilities will be performed without external facilitation or monetary incentives. Following a brief training, they are then able to facilitate regular Community Dialogue Approach sessions involving a range of community stakeholders. They are equipped with a set of visual tools, a guide which contains technical information about targeted diseases and guidance on how to facilitate the process, and identification material (such as a branded t-shirt and cap).

Community dialogue volunteer conducting a meeting, Mozambique

What are the potential limitations of the Community Dialogue Approach?

The Community Dialogue Approach is not a 'magic bullet' and it should not be expected to achieve the desired change on its own or immediately. It is recommended that a combination of SBC approaches are used. The table on the next page can be used as a quick reference tool to understand what the Community Dialogue Approach can and cannot do. This table can help you decide if this approach is appropriate for your programming objectives. Formative research is necessary to understand barriers to social and behaviour change, who is marginalised and why, misconceptions, cultural decision making structures, etc. Understanding these factors will help you decide whether or not the approach is appropriate.

Several countries have also used similar approaches called community dialogues or community conversations. It should be noted that the Community Dialogue Approach is a specific approach based on the principles and assumptions described herein and by following a set of three steps. This guide aims to distinguish the Community Dialogue Approach from other variations of this approach.

Community dialogue mapping, Zambia

The Community Dialogue Approach

can

- Raise awareness about health issues and explore potential causes and ways to resolve them, including perceptions and social norms.
- Support the strategic community engagement to involve those best placed to influence change.
- Promote community participation in action planning and develop self-efficacy in improving health.
- Encourage communities to take ownership over the platform and finding solutions to health issues.
- Help communities to arrive at a consensus on how best to address specific health issues in their communities.
- Target specific audience (participants) within a community.
- Strengthen relationships and build trust between health systems and communities.
- Help to establish sense of social accountability for health.
- Be readily adapted to address a variety of behaviours and health issues according to the needs and interests of the community.
- Be combined with entertaining approaches to appeal to different audiences (including children).
- Mobilise community support for volunteer health workers.
- Develop lasting community engagement skills and social and behaviour change (SBC) approaches.
- Guide programme design and adaptation.

cannot

- **Provide monetary incentives** to volunteers. One prerequisite for community ownership is volunteerism. Implementers may consider other creative mechanisms for sustaining volunteer motivation including; clubs, savings groups, competitions etc.
- **Standalone**. This intervention is not meant to be parallel to health systems, nor should it be implemented on its own. Instead, the Community Dialogue Approach should be sustained and regulated by being fully integrated within existing health systems and community structures.
- **Be used to address all salient issues**. The volunteers must guide the Community Dialogue Session in such a way to recognise the resource limitations present in communities, and provide focus to the areas where the most change can be affected through individual behaviours and social norms. Often, due to poverty, communities may feel discouraged, however facilitators may help them to recognise those actions/ behaviours within their control that can lead to better health outcomes.
- **Address supply-side issues.**

2

Part two: Things to think about

Now that you have determined that the Community Dialogue Approach is appropriate for your context and programme objectives, you should consider the steps provided in the following section: 'Part two: things to think about'. This section outlines considerations to be made when planning and implementing the Community Dialogue Approach. Some of these recommendations apply to creating and sustaining meaningful engagement with communities in general, but all are necessary for designing and implementing a sustainable and scalable Community Dialogue Approach. This section is not meant to be a comprehensive toolkit, and will instead make reference to other well-accepted standards, guidelines and resources where appropriate.

The following 'things to think about' are offered in chronological order according to programme management cycles and best practices from implementation experience, as some are prerequisites to the subsequent. They are grouped into four phases: Phase I: Programme inception and design, Phase II: Pre-implementation, Phase III: Implementation, and Phase IV: Evaluation.

These suggestions are meant to encourage implementers to think about the core elements needed to design, scale and sustain the Community Dialogue Approach as an effective mechanism for community engagement and SBC. You will need to reflect on the principles and assumptions presented in the previous section which must be maintained in order to sustain the fidelity of the approach.

Phase I: Programme inception and design

Careful planning during the inception and design phase is essential to ensure adequate resources are available for all the required steps. The inception phase is an opportunity to advocate for and undertake a truly participatory design process. Using a participatory process can help to ensure plans, tools and materials are relevant and effective, and where possible, integrated for scalability and cost-effectiveness. Ideally, relevant stakeholders who will be involved in implementation should be included in the planning and design of the programme. This phase is also necessary to ensure adequate resources are available to conduct formative research, participatory design activities including message and material development, translation, and pretesting.

1. **Conduct a situational analysis**
2. **Develop research protocol**
3. **Conduct formative research**
4. **Prepare draft design and implementation strategy**
5. **Hold stakeholder meetings and design workshops**
6. **Pre-test materials**

Community member, Mozambique

1. Conduct a situational analysis

In order to understand in more depth the health challenges faced by communities and provide the most insight to volunteers during training, we recommend you first conduct a situational analysis. A situational analysis is standard practice in designing SBC strategies. It consists of a series of desk reviews, secondary data analysis, and sometimes key informant interviews (KII). As part of conducting the situational analysis, you should first ask yourself and your team members the following questions:

- Is there an existing body of evidence and local data which can be analysed to inform the theory of change and identify the causes and possible solutions to the problem you are aiming to address?
- Is this data sufficient in order to develop a theory of change? If not, what additional data do you require? *Note: It may be necessary to conduct your own formative research in order to further explore behaviours and perceptions of target audiences.*
- According to this analysis, is it possible to address the issue(s) through the Community Dialogue Approach?
- Are the causes of these issues on the demand side or the supply side, or both? Is it a particular individual behaviour or a collective decision?

Conduct a stakeholder mapping:

Ask yourself and the team the following questions in order to determine who will need to be involved in supporting design and implementation:

- Which broader health programming could benefit from the Community Dialogue Approach including or in addition to the programme objectives you wish the approach to support?
- How will financial and operational support be mobilised for the integration of the Community Dialogue Approach into existing health strategies?
- What have been the experiences locally when it comes to implementing previous SBC or community engagement strategies? How can the Community Dialogue Approach build on this learning?
- What other supportive policies exist or need to exist (this could also include supply-side strengthening)?
- Is there a health promotion department who should participate in the design?
- Are there experts on your team, or part of larger networks (such as technical working groups or social mobilisation/SBC forums nationally), who have experience with community engagement, or with the specific diseases you hope to tackle with this intervention? It may be useful to include them in a task force/ working group to help design the Community Dialogue Approach for your country and to help foster ownership over the approach and approval. Here you should refer to your project's stakeholder mapping exercise, or conduct one if this has not yet been completed. It is important to involve stakeholders from the beginning so that they can provide necessary endorsements and inform the design and implementation of the approach, especially at sub-national levels where other partners are implementing health programmes. There are opportunities for synergies which can positively impact the effectiveness of the Community Dialogue Approach (coverage, messaging, and acceptability). These discussions will also be informative for deciding how to approach particular health issues, and who in particular needs to be engaged.
- Will the Community Dialogue Approach form part of a broader SBC strategy (complementary approaches being implemented at the same time) or complement other ministerial activities?

RECOMMENDATION

If your answer to any of the above questions is 'no', it may be necessary to create a task force of experts (from relevant health areas and social mobilisation/ SBC experience).*

2. Develop research protocol

Through formative research, the contributing behavioural determinants can be explored in order to help better understand the health challenges faced by communities, and to inform the design of effective strategies and their accompanying materials and messages by incorporating the perspectives of communities. Formative research can help you to understand the issues in more depth and from different perspectives which will help to identify the determinants, behavioural or otherwise, and come up with a theory of change. It can also help you to develop guidance (including key messages) to be included in the training package. In most cases, ethical approval will be required in order to conduct formative research and pre-testing materials. This may need to be obtained from a board of bioethical authorities or via other relevant academic institutions. A research protocol, including research tools, will often be required in order to submit this request. This research protocol should cover all research needed for the programme including: formative research, pre-testing materials, and baseline and endline surveys. These should be prepared well in advance of when the research will be carried out to give time for the bioethics committee (or other relevant authorities) to make the necessary corrections and approval.†

* Stakeholder identification, Stakeholder capacity matrix, gap and synergy analysis, SBC environment analysis (level of national integration, coordinating bodies, human resources, extent of service), https://sbccimplementationkits.org/integrated-sbcc-programs/worksheets/
† Designing Formative research for SBC strategies, https://sbccimplementationkits.org/integrated-sbcc-programs/design/research/

Photo: A community volunteer shows participants pictures demonstrating malaria prevention, Uganda

3. Conduct formative research

Research teams should be identified ahead of time. Ideally, these members will be part of the working group sessions to share findings first-hand. The process will be more streamlined if those who support the formative research also carry-out the later research components, including baseline and endline surveys, as well as pre-testing the tools and materials.

4. Prepare draft design and implementation strategy

Using the results of the situational analysis and formative research, you can put together the draft implementation strategy for the Community Dialogue Approach.*

Design a theory of change

In order to complete the draft implementation strategy, you should first develop a theory of change. This will help illustrate the requisite components and agents of change in order to justify the training of various stakeholders and frequency of the Community Dialogue Approach activities, including support supervision. The theory of change will also help to identify the specific behavioural objectives and influencers to target with messaging. The theory of change may be based on behavioural models, or adapt a combination which is most relevant to your intervention. The theory of change will also assist with developing the logical framework on which the system for monitoring and measuring impact will also be based.

RECOMMENDATION

This is an iterative exercise and it may be necessary to revisit it multiple times. This activity should ideally be carried out as part of a stakeholder working session. Expert opinions and experiences can make it easier to compare your specific behavioural objectives and their determinants against different health behaviour theories.

5. Hold consultative stakeholder meetings and design workshops

In order to advocate for the Community Dialogue Approach to be embedded within the existing healthcare system, buy-in from government and other partners will be required. A case should be made for how the approach can strengthen existing systems by increasing coverage, community participation, and trust. Using your stakeholder mapping, strategically decide who to include in the design and dissemination of the approach. This may mean attending relevant thematic working groups to present formative work and gather input from other interested partners.

These meetings can better help you to understand how other partners are working with volunteers in areas of proposed implementation (are they paid, for instance?) which will impact your volunteer management strategy. Having a set agenda can support you during the meeting to ensure you obtain the feedback you need, and/or express points of interest for achieving buy-in at that level. These conversations will also be necessary for deciding how to integrate best within primary healthcare systems. The purpose of these are to raise awareness and build support for the approach. It is possible that the Community Dialogue Approach will then be adapted

* Operational Considerations For Coordinating SBCC and Service Delivery Programs (coordinating supply-side activities, harmonising messages, sharing data, defining linkages and referral mechanisms), https://sbccimplementationkits.org/service-communication/service-communication-implementation-kit/operational-considerations/

more widely and more resources for scale-up or to address other health challenges will be committed. Stakeholders should be engaged using a series of working sessions as part of the participatory design process. This may provide an opportunity to fine-tune the theory of change before moving on to developing other strategies and tools. Design workshops are ideal for informing the development (and integration) of monitoring and training materials, including key messages, as well as establishing buy-in from stakeholders.

It may also be necessary to adapt existing national training manuals and materials as required, including flip charts with images and messages, volunteer guides, talking points for local leaders, monitoring and reporting forms, and feedback forms. The following tasks can be combined into one working session, or divided into multiple, in order to guide appropriate development.

RECOMMENDATION

Set an agenda and objectives and make appointments with stakeholders ahead of time.

Start with national level stakeholders (technically working groups) and subsequently sub-national level stakeholders, as well as other NGO partners working in the proposed areas of implementation. Be sure to bring along the research proposal and proposed programme design and implementation strategy.

I. Develop a community profile

i. It is first necessary to define the community in order to conduct meaningful community engagement. If we do not understand who the community consists of, and how the community is structured, it will be difficult to effectively and equitably engage them. It is possible to conduct this exercise using the situational analysis and formative research as a source of information, and through KII and focus groups (or ideally a combination of both). You will need the community profile to develop your proposed plan of implementation as well as training materials.

A community profile can be developed using a similar approach to target audience segmentation.

a. The community profile should be developed in a participatory way, working with members from the communities in which you plan to implement the approach. Importantly, this exercise will be used to identify key influencers (who can influence change) and any potential individuals and groups that may be excluded from participating in the sessions due to structural, cultural, or socio-economic reasons. This exercise will ensure diversity and inclusion of participation in the Community Dialogue Approach sessions and the addition of any alternative SBC approaches, such as interpersonal communication or radio programming. Marginalised groups, such as those that may be identified through this exercise, are often the most at risk of encountering health issues. Sometimes these groups may also extend beyond the geographical catchment area of the intervention, such as migrant workers. These individuals are key to disease control and prevention. Marginalised groups will vary by context and the exercise should be conducted with an open mind, allowing for the possibility that new or unknown groups may be identified. This process is especially important, as the approach should be careful not to entrench discrimination or biases any further. One focus of volunteer training is to ensure that volunteers have the skills to amplify the voices of those who are most vulnerable and ensure that such people are included in the approach.

b. As part of developing a collaborative community profile, you will also be able to define key roles and responsibilities of all stakeholders and understand how best to leverage existing structures and individuals of influence.

c. This exercise will also help you to determine the potential ideal profile for the volunteers and the recommended selection criteria to be used by the communities when recruiting volunteers.

d. Furthermore, the community profile will also help to inform the audience segmentation and targeting of participants in the Community Dialogue Approach sessions, according to topics of relevance.

e. This exercise can also help you to design any formative research (including who you may need to interview in the form of KIIs or focus group discussions you may need to do as part of designing your programme).

II. Set selection criteria for volunteers

The ideal volunteer profile should be agreed upon by stakeholders, however see below for recommended selection criteria. For example, if the same individuals who are selected as the Community Dialogue Approach volunteers also have a role as community health workers, this may affect their ability to facilitate community dialogue activities regularly or vice versa. As part of deciding on the criteria for volunteer selection, a volunteer management strategy should be created in-line with national strategies for community health volunteers. For example, if community health workers are not provided any monetary incentive, neither should the community dialogue volunteers.

As a general rule, for sustainability, non-monetary incentives are best (for instance, establishing support mechanisms and providing rain coats, boots, bags, t-shirt, certificates or even forms of identification such as name tags), which should also be considered as appropriate to the context.

Furthermore, depending on the implementation context, it may be advantageous to enrol the primary community health worker as the volunteer. This will depend on the work load, and capacity of the volunteers and must be agreed upon by appropriate authorities. This plan should come out of the design meeting on implementation strategy.

Over time communities will need a system for cross-training replacement or new volunteers and may even want to adopt a rotation schedule where a new volunteer takes over from the last when there is a new topic to tackle. The new individual can become the champion for that issue and be responsible for monitoring progress and determining whether or not roles and responsibilities have been fulfilled and outcomes achieved. This may depend partly on the size of the community. The previous volunteer would need to pass on the skills they developed to their successor.

RECOMMENDATION

Example selection criteria for community dialogue volunteers:

1. Volunteers should be community based, meaning they reside in the community in which they are expected to implement (as not to incur transportation costs).

2. Volunteers should possess basic literacy skills (a recommendation from prior implementation is that basic reading and writing skills should be determined prior to

Flip charts used by a community dialogue facilitator with a group in Bangladesh

3. One male and one female volunteer should be chosen from each community of implementation.

4. Volunteers should be respected by the community in which they reside.

5. Volunteers should be energetic and dynamic.

6. Volunteers should have three to four hours of free time per month.

The Community Dialogue Approach volunteers will be most effective if they have experience facilitating the Community Dialogue Approach dialogue session, though this does not need to be a criteria as the training covers facilitation skills. It should be noted these skills are different from health promotion, social mobilisation, or health education.

III. Identify key topics and define key messages

In order to define messages, the following questions must be answered:

- **What health topics will be covered?** Will topics cover entire disease cycles? Will this be covered over multiple Community Dialogue Approach sessions?

- **Are these health topics also included in national campaigns?**

- **Will the Community Dialogue Approach implementation align with any other national campaign?** Messaging should be consistent nationally to avoid confusion and emphasise the message. For example, mass drug administration campaigns for malaria prevention could be an opportunity to discuss related issues among communities.

- **What messages are required for each health topic?** Messaging will need to be persuasive in order to support and encourage the desired behaviour. Messaging should be based on current understanding, beliefs, and practices in the local context (from the formative research). They should also address commonly held beliefs or misconceptions in a respectful way. These context specific messages can be adapted according to the issues identified in the situational analysis and formative research. This will help ensure understanding and adoption of new messages. It may be necessary to revise existing national materials as part of this process.

- **How long will the topic need to be covered by a particular community?** Guidance must be given to volunteers during training on how long to spend on a particular health topic and the cues they should look for to know when it is time to move on to another topic. This can be informed by the responses of participants during Community Dialogue Approach sessions.

- **What needs to be translated, in which languages, and for what level of training?** Make sure to pre-test these messages with target audiences.*

IV. Design your system for measuring and monitoring impact

A logical framework should be developed and used to guide development of monitoring tools and strategy. This logical framework will be informed by the theory of change. Monitoring and support supervision should be integrated into existing health system structures where possible. This will need to be agreed upon by relevant stakeholders.

The following questions can help you and your team in designing appropriate systems and tools for monitoring the Community Dialogue Approach:

- **Will the community dialogue monitoring tools be integrated into existing health information systems or separately?** This will depend on the scale of implementation and ownership by the government health systems.

- **What indicators need to be measured?** Think output and outcome in addition to process indicators.

- **Will these monitoring tools be paper based or electronic?** *Note: qualitative feedback from a Community Dialogue Session is often easier to collect and compile using paper based forms.*

- **At which levels will data be collected and compiled? What tools are needed for these steps?** This will also depend on the literacy levels of the volunteers and may require more support from supervisors. Who will review the data at each level?

- **How will feedback be gathered from implementers and communities?**†

* How to develop materials, https://www.thecompassforsbc.org/how-to-guides/how-develop-sbcc-creative-materials
† How to develop a logic model, https://www.thehealthcompass.org/how-to-guides/how-develop-logic-model-0

V. Develop training and facilitation materials

The training package can be developed based on the topics, strategy for implementation, and monitoring system. According to available resources you may want to first decide how many days of training can be provided for each level of implementer. Ideally, the volunteer training is four days. The strategy for training should be defined, for example, this could be a cascade training method. Ask yourself and the team:

- **Will this be a cascade training?** Who will be responsible for carrying out the training at each level?
- **Who will be the master trainers?**

In order to design your training manual, you may ask yourself and the team the following questions:

- **Will a cascade approach be used in order to carry-out the trainings at the community level?**
- **What training materials are required, for which levels?** Will the training package require flip chart or flash cards? Are your volunteers literate?
- **What is the current level of skills and experience of the stakeholders involved in implementation?** Training manuals should build on existing experience and be relevant for each level of implementation (master trainers, supervisors at heath facility level, volunteers, and community).
- **What materials already exist?** In the experience from the Malaria Consortium pilots, the flip charts were highly appreciated by volunteers and communities. These materials also give the volunteers legitimacy as experts on health topics as they provide evidence that the volunteer has completed training. They also make it easier for volunteers to make technical references. Images used in the materials should conform to the nationally approved image style and graphic design style, so they are recognisable and consistent with other materials used at the health facility and community level.

The following questions should be included in the training package and volunteer guide as they will need to be considered by each volunteer when designing the implementation plan for their community. Guidance should be provided to assist the volunteer in designing the optimal plan.

- **Where should the community dialogue sessions be held in the community?** A common meeting place is most appropriate, though this will be collectively decided by volunteers and local leaders.
- **How long do the sessions last?** Each Community Dialogue Session should last no longer than two hours, with all three steps covered.
- **Who from the community should participate? How many people can participate during one session?** Keep the group small so that everyone gets a chance to talk. It is also more difficult to manage a big group. Small groups (20 to 40) are better for exploring in-depth and coming up with realistic and specific plans of action.
- **How often and for how long should the Community Dialogue Approach be implemented?** This guidance should come first from the theory of change, then be adjusted according to the feedback obtained during Community Dialogue Approach sessions. The intensity and duration of covering a topic will depend on the acuteness and urgency of the health issue, and how resistant the community is to change (ideologies and misconceptions which are rooted in culture and religion).

Prior implementation experience has found it useful for volunteers to also receive a manual which they can refer to for guidance on how to conduct Community Dialogue Approach sessions and technical information about the target health topics. Importantly, completed correct examples of the monitoring forms should also be included in this manual as a reference, as reporting is often challenging. These examples are available along with training packages from Mozambique and Bangladesh and can be accessed through the Malaria Consortium website.*

It should be noted that these training packages are specific to the intervention and would need to be modified for future use.

VI. Pre-test materials and present results to stakeholders

The materials should be pre-tested in a sample of the areas of implementation. Ideally all tools should be pre-tested with stakeholders presenting the various levels of implementation (both communities and volunteers or equivalent). Invite partners at district level to participate in the pre-testing of materials, then present findings from pre-testing to national level stakeholders. Present the findings from the pre-testing exercise to the relevant technical working group or stakeholders for final approval.†

VII. Present plans and tools to stakeholders

Present drafted plans and tools to technical working groups for feedback and approval. Similar meetings should be held at sub-national levels where appropriate, and all feedback from these meetings should be incorporated into final tools and protocols.

* Malaria Consortium resources, www.malariaconsortium.org/resources/publications/add-type/training-materials
† How to test creative concepts and materials, https://www.thecompassforsbc.org/how-to-guides/how-test-creative-concepts

Phase II: Pre-implementation

6. Conduct courtesy visits
7. Conduct baseline survey
8. Recruit volunteer facilitators
9. Conduct training of trainers

6. Conduct courtesy visits

Using your stakeholder mapping, plan for courtesy visits prior to completing implementation activities. Agenda items for the visits should include but are not limited to:

- what the community dialogue approach is and what the objectives of implementing are in the context of broader health programming
- findings from formative research and pretesting, approvals from national level (ethics and materials)
- recruitment of volunteers, including selection criteria (gender balance)
- training plan (cascade training)
- roles and responsibilities at all levels
- monitoring and support supervision schedule
- endline survey and impact assessment
- dissemination workshop.

Discussing these points is necessary to create buy-in at these levels and is another way to ensure implementation strategies are reasonable and acceptable to those who will be responsible for carrying them out. These meetings will also inform the development of the training agenda and materials, monitoring plan and reporting style, and will determine the level of capacity building in areas such as technical content, facilitation, monitoring and reporting. It can also be strategic to keep in touch with these stakeholders.

RECOMMENDATION

WhatsApp groups can be used to keep all stakeholders informed, or SMS can be used to give updates on progress and reminders for meetings. It can be useful to keep both national and sub-national groups informed.

7. Conduct baseline survey

The baseline survey should be conducted prior to pre-testing of materials and training of volunteers. This order is important as you do not want any information from the training or pre-testing of materials to influence your baseline data. This baseline data, in combination with formative research, is used to design the theory of change and messages.

8. Recruit and register volunteer facilitators

During stakeholder consultations, you will agree on the selection criteria for volunteers and decide who will be responsible for overseeing the selection of volunteers. This is arguably the most important point when implementing the Community Dialogue Approach. These stakeholders are partially responsible for ensuring that selection criteria are maintained and ultimately that the best volunteer is recruited from each community. To further ensure criteria are followed, it is recommended that there are two bodies involved in the selection of volunteers.

This process can be transparent if the stakeholder engagement is detailed from the outset and a community profile is well developed. There must be a strong understanding of community dimensions and dynamics as well as a clear explanation of the purpose of the programme and requirements of the volunteers. This is necessary in order moderate expectations of all stakeholders, to find the most appropriate volunteers, and to keep them engaged throughout implementation and beyond. The most important point is to emphasise the need for facilitation skills, as compared to health promotion. It is also recommended that a volunteer register is created which captures contact details, community and health facility coverage area, gender, and relevant experience working in communities.

RECOMMENDATION

In Mozambique, those in-charge of the health facility and vice-president of co-management committee were responsible, in collaboration with village leaders, for identifying volunteers in each community. This enabled collaboration between the health and community structures, ensured the selection of appropriate volunteers and mitigated bias that could affect selection if done unilaterally.

9. Conduct training of trainers

Carry out the first levels of the cascade training, up to the point of volunteers. Ensure back-up volunteers are also trained as a contingency measure and all trainers have the required language skills to complete subsequent levels of trainings. It should be noted that volunteers are not meant to be health experts. Rather, they should be experts in facilitation and guiding community participants through reflective and empowering discussions.

RECOMMENDATION

It is recommended that master trainers are paired with those with complementary skills. For example, in Mozambique, the NTD focal points from the provincial level were paired with a district level health promotion representative (or vice versa).

Phase III: Implementation

10. Train volunteers

11. Report and monitor

12. Support, supervise and act on feedback

10. Train volunteers

Training of community dialogue facilitators is completed according to the cascade training strategy developed as part of the implementation plan. Each training session should be completed in groups of volunteers comprised of no more than 30 individuals. There should a minimum ratio of two trainers for every 30 participants. It can be useful to conduct one training of volunteers in one region before finalising the training manual, and have all the TOT participate in this first training.

Training agenda should include the following:

- technical disease and health related information
- planning for community-based activities
- facilitation skills, mediation, complaints handling
- monitoring – decision log, correctness and completeness of monitoring tools
- support supervision and feedback meetings – what to expect.

RECOMMENDATION

Pre-post knowledge tests can be useful to measure the effectiveness of the training, however monitoring data and support supervision visits can help to determine whether or not a refresher training is needed in a particular region. Indications could be: poor volunteer performance, low knowledge in the communities, or complaints raised by participants or non-participants.

11. Report and monitor

Monitoring and reporting should be completed according to the system for measuring and monitoring impact. This system should track programme outputs and progress towards specific behavioural objectives and health outcomes, as well as inform programmatic decision making throughout implementation. Data aggregation from community to sub-national and national levels should be integrated for ease of completion and oversight at points of responsibility.

12. Support, supervise and act on feedback

Support supervision is particularly necessary in the first few months of implementation. Since the intervention will still be new, volunteers will require guidance. Support supervision visits should take place regularly, with sub-national level focal points as the lead (integration into the existing structure of routine health monitoring and is ideal for sustainability).

RECOMMENDATION

Feedback meetings, held with focal points from sub-national, health facility, and community levels can be useful to reflect on implementation progress and need for adaptation. This is also an opportunity to provide in-depth support (coaching) to implementers. Feedback gathered from these meetings should be reflected in the support supervision reporting form and any actionable items should be followed up on by responsible parties. This could mean making adjustments in the implementation strategy and is worth sharing with other implementation areas.

Feedback sessions may include:

1. looking at how the Community Dialogue Approach has been received in communities and whether the population participated in the Community Dialogue Approach sessions
2. reviewing whether a good relationship has been created (or continued) between the volunteers and the members of other community health structures and health service providers
3. looking at what observable or reported change in behaviours has taken place
4. ensuring monitoring forms are being completed correctly and reviewed
5. sharing strengths and weaknesses of implementation thus far and collecting lessons learnt
6. discussing introduction of new topics
7. devising a plan for transition to scale up
8. conducting a refresher training for volunteers.

Phase IV: Post-implementation

13. Evaluate impact

14. Share experience and findings

13. Evaluate impact

The acts of community problem identification, group decision-making, action planning, collective action, and implementation are critical to how a community grapples with serious issues.[9] When a village or group undertakes this process, as in the Community Dialogue Approach, they have already affected positive outcomes. The process is therefore equally as important as the behavioural and health outcomes.[10] Therefore the process must also be captured in order to adequately measure impact. Evaluation should also include comparative analysis of baseline with endline data and as well as triangulation with routine monitoring data, including feedback from communities and any other relevant health indicators available.

RECOMMENDATION

14. Share experience and findings

Sharing experience will help to sustain and improve the Community Dialogue Approach. Dissemination workshops at national and sub-national levels are useful when advocating for scale-up or expansions and other participatory methods for developing ownership that are necessary for sustainability. This is especially recommended if a harmonised approach is being considered at the national level.

There is now global interest in the Community Dialogue Approach. Further evidence demonstrating its ability to affect change needs to be shared, along with evidence on how best the approach can be scaled-up and sustained.

Community members wait for the community dialogue to begin, Nigeria

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