COVERAGE MONITORING NETWORK

Community-based mobilisation in Mali

A guideline of operational activities

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Contents

Introduction 2

Lines of work 3

Step 1: Qualitative assessment 3

Step 2: Get the community involved 4

Step 3: Community-based activities 5

Conclusion 8

Introduction

Implementation of a real community-based mobilisation to improve coverage of CMAM programs implies to re-examine donors' strategies, as well as the field operators ones. This document is a synthesis of operational orientations aiming to achieve a health community-based approach applied to the fight against acute malnutrition interventions of children living in Sahel countries, such as Mali.

The coverage assessments implemented in this country contribute to promote the emergence of a new approach: the barriers to access identified result, among others, of the quality of the care supplied. Nevertheless, a certain amount of social and cultural facts highly impact the therapeutic use of malnourished children. This is even more important in the context of community-based treatment, daily lived by ill children' families.

That being established, a change of stakeholders' positioning seems required, as well as the one of target population. This document will not go back to humanitarian assistance history, neither to public health orientations, but we can collectively note that interventions against malnutrition rich their limits. The efforts made by Ministries to recognise malnutrition as a public health issue have allowed the adoption of national protocols framing prevention and management of malnutrition. In Sahel countries, as well as in other African regions, these strategies integrate community mobilisation as a part of the fight against the illness. From their side, NGOs, generally working supervising public services, have accompanied the implementation of these activities.

Despite the declared intentions of a more participative approach, it appears that communities feel relatively strangers and little concerned by the objectives planned of their "own" mobilisation. The implementation of community volunteers – whose efficiency is variable and random – hasn't been enough for the communities to feel involved in the fight against malnutrition. Values of CMAM program coverage show this issue: the amount of children treated doesn't match the expectancies planned and the financial and human efforts realised. This leads to a decline in projects realisation: health workers and field staff share a kind of demotivation, the usefulness of the budget allocated is not ideal and the populations show a certain scepticism, and sometimes a disinterest, for the projects in which they are the direct beneficiaries.

Several reasons may explain the situation and propose a path to find solutions.

The CMAM approach, despite its community-oriented intentions, remains most of the time standardised. The experience of the CMN assessments realised conducted to a contextualised analysis of targeted populations and to the identification of barriers to health services access in a socio-cultural determined environment. All types of action that we are going to present in this document must be discuss with the communities. A qualitative evaluation will allow, case by case, to assess the feasibility of the actions planned, their adaptation to lifestyles and to cultural facts to whose they are linked. This endeavour adaptation shall not be associated to cultural relativism or to a "culturalist" over-interpretation of things. It must allow to rely on an experienced reality but also to aim certain forms of social transformation, essential objective of community-based health actions: re-appropriation of health issues for targeted populations, autonomy of community-based actions to solve them, women empowerment, individual and collective capacity building, etc.

In this perspective, communities will have to share the responsibilities of the successful actions, as soon as they will be part of it, as authors and actors. The end of a vertical public health frame will go through a positioning modification of each other: from the aid relationship we will go towards a cooperation relationship. On the one hand it will allow to guarantee a better adhesion of families to CMAM programs, an adapted and sustainable response to health access barriers. On the other hand, the restoration of the trust between health stakeholders and populations will rely on a higher resources and constraints of health structures and NGOs transparency. To reach this configuration, it is required that donors get simultaneously engaged in this direction, supporting, for a low cost, community-based mobilisation initiatives.

Lines of work

The nature of community-based health actions implies an active participation of these communities to elaboration, implementation, monitoring and evaluation of health projects. The solicitation of communities, on the field, is generally reduced to the delegation of activities: "we don't have the resources to broadcast prevention messages, so we ask the community health workers to diffuse them". The inefficiency risk is thus important: the message may not be adapted? The community health workers may not have understood it? Their audience is limited? Or also their availability or capacity de diffuse it? The community-based approach consists to elaborate messages with people from the community, identify with them the terms to choose, the ways of communication the most efficient regarding the target population and evaluate with them the impact of the message delivered.

Step 1: Qualitative assessment

Health stakeholders integrate the comprehension of the socio-cultural environment of their intervention area. They can make occasional qualitative assessments to identify what impact health programs. Quantitative data are generally available because of the high amount of surveys implemented (SMART, KAP, etc.) and the statistical management of

nutritional data systematically collected by States as well as by NGOs. The qualitative approach will bring a complementary meaning to this data: a percentage of children who doesn't access program, it is a must to understand why, who influences the therapeutic itinerary of ill children, how malnutrition is integrated into the traditional medical corpus, etc. We know generally "how many", we must now know "why" and "how". Beyond qualitative assessments – for which we mention again that they do not need a lot of human and financial resources and that they will certainly allow to save money and energy on a long run – the collection of this type of data may also be part of a routine work from field stakeholders, during their visits to health facilities or villages.

The socio-cultural environment analysis useful to CMAM includes the following points:

- Social structures and hierarchy, community organisations and authority relations
- Gender relations, familial organisation and inter-generational relationships
- Religions, believes, cultural approach of medicine and health (etiology, therapeutic efficiency representation, signs interpretation, decisional power regarding the use of care, etc.), malnutrition perception and therapeutic itinerary of children (self-medication, street drugs seller, traditional medicine, magic-religious rituals, access to public and private health services, etc.)
- Biomedical medicine perception, programs and drugs (Plumpy Nut) perception, relationship between health carers and patients, real and provisional costs of care.

Step 2: Get the community involved

This step must outstrip the theoretical approach that we see too many times on the field. As said above, the absence of an efficient participation from the community weakens the trust with health stakeholders and lead to unwanted situations: too many testimonies from both sides describe a situation of incomprehension. The community may think that malnutrition is only the problem of sanitary authorities or NGOs who "act when they want and give up". Professionals get discouraged of families who "don't understand the issues and neglect their children' health", or also of community leaders who "won't do nothing if we don't give them per diem". This reciprocal misunderstanding will disappear by the association of communities to the project cycle and the increase of a dialogue between operators and target populations.

Qualitative assessments described in step 1 will furnished opportunities to identify the more motivated community representatives to participate and form a referential work group for humanitarian workers and health professionals. This group, which does not aim to be fixed, should be representative of all segments of the society: mothers of malnourished or cured children, men, customary or religious leaders, healers, women groups' representatives, etc. However, we must note that the humanitarian experience demonstrated that "artificial" groups created for a project needs are not coherent and sustainable. It is better to rely on existing groups and prioritise field trips before the creation of a work group dedicated. In Mali, a lot of community structures already exist: tontines, women associations, healers' guilds, agricultural cooperatives, villages' chiefs associations, etc. Each of them has the capacity to nominate a speaker for health projects. Participation of mothers and fathers of children admitted or discharged of programs is an absolute condition of a community-based health strategy. Some activities (e.g. prevention pre-test tool) may rely on a direct examination in villages.

Participation of the community will be articulated around the following points:

- Sharing of programs information: project stakeholders, allocated resources, project's objectives and duration, restitution of results from surveys implemented in the area, issues met, etc.
- Meanwhile, the community representatives may suggest and guarantee the commitment monitoring of the groups they represent

Step 3: Community-based activities

Barriers to identified care access analysis during the coverage assessments showed that the barriers, specific according to the context, may be grouped in different big tendencies. The list is not exhaustive but some barriers appear as recurrent and predominant. Community mobilisation should bring alternative and innovative responses; that moreover will be based on inhabitants' dynamism.

Let's note that on a transversal way, community mobilisation activities should particularly focus on the gender issue. In this Sahel region, decision-making, financial and material power is mainly in men' hands. Yet, sensitisation activities target systematically women, who appear as the only ones responsible of children health. Women need fathers' support in order to go beyond barriers to health access developed above. Orientations should be more focused on men' implication and sensitisation.

Barrier 1: Lack of awareness about malnutrition and the program

Actions to consider:

- Creation of information messages with the community representatives as well as diffusion strategies:
  - Key messages: most appropriate terms in local language to designate malnutrition (be careful to avoid pejorative words), free access, length of treatment and consequences of acute malnutrition
  - Choice and mobilisation of communication channels the more relevant regarding the nature of the message or the targeted population. E.g.: micro-mosque to sensitise men; diffusion through tontines to inform women; villages evenings meetings and public criers for the whole community; community health workers to inform villages' chiefs; motorcycle-messengers for nomads camps; postings through boards in health facilities about free cares and prices of offered services; etc.
  - Intensify the information given to mothers of children admitted in the program. Word of mouth is a very efficient channel of communication, mothers satisfied are the best ambassadors of the program.

Barrier 2: Distance, difficult access to transport

Actions to consider:

- Mobilise the available resources in the community
  - Ask the villages' leaders and mayors to organise transport and escort the children: provision, the day of program, of transportation from the village (charrette, motorcycles, pirogue, etc.). The village's chief

may also designate one or two men to escort women and children the CMAM management day to the health facility (to limit the insecurity during the travel, support the mothers' effort or be aware of the management issues such as drugs stock outs)

- Adapt the management for remote and landlocked areas
  - Adapt the management according to the seasonal calendar: twice of the RUTF distributed for the landlocked or non-accessible area during rainy season
  - Establishment of mobile teams for remote areas and nomads populations
  - Guarantee an efficient children transfer for nomads or mobile seasonal workers (e.g.: in rice-plantation region) children
  - Integration of secondary centres and eventually of private centres

Barrier 3: Poor screening

Actions to consider:

- Screening by community health workers is a major axis for a high amount of implemented community mobilisation strategies. But limits of community health workers are appearing: they are not always motivated nor available for volunteer tasks, sometimes they are not considered as legitimate by the health professionals from the health facility or by the population itself, not systematically well trained, equipped or supervised. It is becoming urgent to revise their role and attributions. A lot have acquired a status and knowledge that we must not take back. They remain the interface between the community and the health facility. Nevertheless, screening is a key and strategic step to an early admission, which cannot be entirely left depending on motivation and availability of community health workers. They get a lot of solicitations from different programs and structures and will choose what is the most lucrative among those choices: volunteering is hardly sustainable in a long run.

  - Get the screening wider: this measurement should not be seen any more as a particular attribution. Lots of people in a village are able to use a MUAC and to read coloured results. It could become a common measurement, available to anyone and especially to mothers of under 5 years old children. It is desirable for this easy-to-use and cheap tool to be massively distributed: mothers of cured from malnutrition children (which would promote the child's monitoring and limit relapses' risks) who would be able to screen others children of the village, traditional healers, midwives, grand-mothers who take care of the children during the day… This local screening would then be confirmed by community health workers who would guide children for their management.
  - A wider screening strategy would also increase the chance to cover areas and populations non-covered: farming and tutelary hamlets, peripheral huts, marginalised populations
  - Adapt screening campaign calendar to agricultural activities and seasonal barriers

Barrier 4: Children therapeutic itinerary, use of traditional medicine

Actions to consider:

- Every ethnic group or sub-group has its own health culture and therapeutic behaviours. For the ill children families, use of health care is determined among loads of therapeutic offers which moreover do not exclude each other's and can be used simultaneously. This choice is determined by different factors: influence and positioning of the decision-maker member of the family, financial costs, believes, physical proximity, perception of therapeutic efficiency or therapist legitimacy, modern medicine representation… Based on that we give home-made infusion to children (auto-medication), traditional treatments more or less invasive and harmful, drugs bought to street sellers or also magic-religious practices. Facing this "competition", testimonies often confirmed that health facility is the last choice, chosen when others attempts failed. In addition to a late admission when the children status are very bad, this amount of different choices may also be the reason of CMAM default if it is judged non-efficient, too long or too constraining.

    - Identify the different therapeutic options, what determine choices and who decide what is the best choice for the ill child
    - Work on a collaboration with the traditional healers: some of them are structured in association. It could be possible to cooperate with them, having in mind constraints which influence these collaborations: suspicions between the two medicines that are considered as competitors from one another. So it is about to find a win-win deal with the traditional healers: e.g. screening and orientation of children with in counterpart a support with the creation of medicinal plants gardens (close to health facilities?) or also a technical support to the valorisation and scientific expertise of traditional treatments (publication of a glossary, support to research on traditional treatments, etc.)
    - Strengthen prevention messages linked to drugs from street consumptions or from street-sellers and the risks they bring
    - List the offers of private care (e.g. clinics) and evaluate possibilities of cooperation: training on malnutrition in counterpart of screening and orientation of children for instance, or integration of some private structures to CMAM
    - Reorganise distribution of MAM drugs: Plumpy Sup stock outs are often seen in interviewed countries. We cannot deny that a mother who has overcome many difficulties to arrive to the health facility and who has to go back home without any treatment for her child, will be discouraged and will give a very bad image of the program in its whole (she may not distinguish MAM and SAM management)
    - Rejection or poor delivery of services in health facilities constitute also reasons of defaulting or treatments refusal within the health facility. Training of health workers regarding the quality of services delivery regarding the impact on program coverage would be necessary. The involvement of CMAM actors in the trainings of health workers would contribute to improve the relationship between health carers and patients

Barrier 5: Lack of money

Actions to consider:

- CMAM programs implemented in Sahel region are, for the most part, free of charge for families. Yet, a lots of testimonies in villages confirm that parents think they don't have the financial resources to bring their children to the health facilities. This could be explained by different reasons: they ignore that the treatment is free of charge; the free access is not implemented; they consider additional costs (transport). Here again it appears compulsory to rely on community mobilisation to reduce these barriers.

    - The free access of treatment information for SAM must be more widespread via the use of the communication channels mentioned above. To guarantee the efficiency of this gratuity but also to inform about financials costs related to health management (associated illnesses, MAM cases in some areas, etc.), it would be good to display a board explaining the different services and prices of the health facility
    - For the additional costs, mutual community-based assistance structures already exist and deserve to be more investigate to financially help families of ill children: e.g. tontines or mutual assistance

Barrier 6: Mothers busy and husband refusal

Actions to consider:

- Availability of mothers is random: it is not always easy to dedicate a whole day to go to the health facility with the ill child, every week. It means no work in the field or other productive activities, no care to the others children of the family or the husband (rota in polygamist families), nor house chores. Thus, the time dedicated to the ill child represents a cost to the whole family. Gender approach in these regions implies to get the husband approval to follow the treatment during several weeks.

    - Explore the possibilities of baby-sitting within the community during the days of CMAM management (e.g. with the help of grand-mothers)
    - Strengthen men sensitisation to the treatment benefits via villages leaders, religious leaders or families chiefs
    - Support the escort of mothers and children by men from the village, under the influence of the leaders

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Conclusion

The community-based mobilisation strategy proposed here implies, as we said, an evolution of positioning but also new methods of cooperation and partnership: universities, associations, women groups, religious structures, etc. We must consider that community health management allows to mobilise different segments of the society and thus to share tasks and responsibilities.

Barriers mentioned here, as well as lines of work to reduce their impact, are not exhaustive. Their identification must result from a qualitative assessment on the field and their solutions from the active cooperation of the community. The funding of both surveys and jobs dedicated to community mobilisation is a key point to support this dynamic. However the actions planned are not expensive and can contribute efficiently to the fight against malnutrition, to programs coverage and, finally to their efficiency and the improvement of relations between health stakeholders and community. Community-based health actions respond to, at the same time, ambition of involved and proactive populations, States' and NGOs' constraints and terms, and finally to the donors objectives.

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