



# Malaria Control Tools

## Malaria Community Competence

A Midterm Evaluation of the Malaria Community Competence Process In Nine African Countries

**March 2009**



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## Abbreviations

ACC.....	AIDS Community Competence
ACP .....	AIDS Competence Programme
BP.....	British Petroleum PLC
CBO.....	community-based organisation
e-Workspace.....	UNAIDS' electronic information-exchange workspace
GFATM .....	Global Fund to Fight Aids, Tuberculosis and Malaria
ITN .....	insecticide-treated nets
IRS .....	indoor residual spraying
IPT.....	intermittent preventive treatment
KA.....	knowledge asset
LLIN .....	long-lasting insecticidal nets
MCC.....	malaria community competence
MOH .....	Ministry of Health
NGO.....	nongovernmental organisation
NMCP .....	national malaria control programme
NSGA .....	Nova Scotia Gambia Association
PHE .....	peer health educator
RBM .....	Roll Back Malaria
SA .....	self assessment
SALT.....	Support to Action Learning and Transfer
SMoC.....	self measurement of change
UNAIDS .....	Joint United Nations Programme on HIV/AIDS
UNITAR .....	United Nations Institute for Training and Research
USAID .....	United States Agency for International Development
WHO.....	World Health Organization

## Background

The “competent community” was defined by L. S. Cottrell, Jr, in 1983 as “one in which the various component parts of the community are able to collaborate effectively in identifying the problems and needs of the community; can achieve a working consensus on goals and priorities; can agree on ways and means to implement the agreed on goals; can collaborate effectively in the desired actions.”

The concept of community competence with respect to a disease condition originated with the AIDS Competence framework developed between 2003 and 2004 by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in partnership with the United Nations Institute for Training and Research (UNITAR), British Petroleum (BP), the Salvation Army, the World Bank Institute, and a number of nongovernmental organisations (NGOs) and local authorities.

In July 2005, shortly after the release of UNAIDS’ evaluation of AIDS Community Competence (ACC), the concept was extended to Malaria Community Competence (MCC) at the request of the Roll Back Malaria (RBM) secretariat. The Belgium-based NGO called The Constellation for AIDS Competence was contracted to launch MCC through a workshop for facilitators from July 19 to 22, 2005, conducted in Mombasa, Kenya. Nine African countries participated: Benin, Cameroon, The Gambia, Kenya, Nigeria, DRC, Sierra Leone, Tanzania, and Uganda. Financial assistance for certain activities was provided by the pharmaceutical company of Sanofi-Aventis.

Participants at the Mombasa workshop included people with communication or facilitation skills working with their countries’ national malaria control programmes (NMCPs) or with large malaria projects run by NGOs or bilateral agencies. These included United Nations Children’s Fund (UNICEF), Red Cross, and World Health Organization (WHO).

The workshop led to the formation of the so-called Mombasa Group, consisting of those who had acquired skills in facilitating MCC processes there. In the two years since then, several of these facilitators have started MCC processes and activities within their countries—specifically Benin, Cameroon, The Gambia, Sierra Leone, and Tanzania. In nearby Togo, where MCC activities were spurred on by The Constellation’s coach there, Dr Blaise Sedoh, the MCC approach has been adopted nationally by the Red Cross. In Sierra Leone, World Vision Sierra Leone intends to adopt the MCC approach in all its national work. The MCC approach has made limited progress in the other participant countries.

This document will set out the results of an evaluation of the MCC model as implemented by the Mombasa Group, to identify what has worked, what has not, and what could work better.

## Defining malaria competence

An informal description of MCC exists in a 2006 presentation on the MCC process made by Alexander Ostwalder, former business manager of The Constellation:

We envision malaria-competent societies where individuals, families, and communities openly acknowledge that malaria is a matter that concerns them, they act to prevent its effects, and mobilise in their environment the support they need to maintain the quality of their lives.

In a malaria-competent society, we—as people in families, in organisations, and in policymaking—act from strength to acknowledge the reality of malaria, build our capacity to respond, reduce our vulnerability to risk, allow everyone to live out their full potential, and share our experience with others.

This description, borrowing quite literally from the definition of AIDS Community Competence (ACC), expects five characteristics in a malaria-competent community:

1. It recognises the reality of malaria;
2. It builds its capacity to respond to malaria;
3. It exchanges and shares knowledge and skills;
4. It reduces its vulnerability and risks of malaria; and
5. Its members live to their full potential.

## How the MCC model delivers results

The various community competence models (AIDS, malaria, and others) typically do not include funding mechanisms, and thus do not aim to create new programmes, but rather energise and enhance community participation in ongoing initiatives. They do this by introducing new reflective methodologies that include community self-assessment and planning processes. Any new community-level initiatives that emerge from this would be financed through community resources. Officials of The Constellation working on MCC add that it does “require some strategic shift in mindset from interventionist towards facilitating local responses.” They emphasise that the tools are useless when applied with the wrong mindset.

## Stages of the MCC approach

The MCC model borrowed many processes and tools from the ACC approach. Since the tools are disease-independent, there is no anomaly in this. The broad stages of introducing and implementing MCC were:

1. **Country identification:** The RBM Secretariat identified countries with strong and active malaria prevention and control programmes at the national government level, and also the presence of NGOs and international NGOs running malaria projects at the regional and local levels.



2. **Participant selection:** The various governments and NGOs, in consultation with RBM, nominated national, regional, or local-level facilitators to undergo training in the processes and tools for introducing the MCC approach. An important selection criterion was a background in communications and facilitation skills, with an orientation towards community autonomy and participation.
3. **Training workshop:** The Constellation conducted a workshop in Mombasa to create skills in administering the MCC tools and processes among the nominated national-level facilitators. The training was conducted by designated coaches from The Constellation's ACC team.
4. **Community self assessment and planning:** The facilitators trained other facilitators in their local settings on how to introduce MCC processes. Facilitators conducted self-assessment processes with interested communities to identify their strengths, weaknesses, needs, and priorities, and developed activity plans.
5. **Knowledge management:** The Constellation moderated a Yahoo! group for the sharing of knowledge, experiences, and best practices. Where possible, they promoted face-to-face interactions and the creation of knowledge assets (KAs) and knowledge fairs.

At the community level, the MCC process starts with a preliminary “appreciative” visit (formally called a SALT, or Support Appreciate Listen Transfer, visit) by the trained facilitators to establish a relationship with the community and help develop the community's dream of malaria competence. They help the communities conduct self assessments, which help participants identify their strengths and needs (weaknesses) on a five-point scale in 14 different areas related to malaria prevention and control. These areas comprise:

1. Community attitude towards malaria.
2. Acknowledgement and recognition of malaria as a disease.
3. Including the most vulnerable in the response to malaria.
4. Access to appropriate and timely treatment.
5. Perception of malaria's severity.
6. Prevention: insecticide-treated nets (ITNs).
7. Prevention: indoor residual spraying (IRS).
8. Prevention: intermittent preventive treatment (IPT).
9. Gender-driven response.
10. Learning and transfer.
11. Measuring change.
12. Adapting our response.
13. Ways of deploying our own strength.
14. Mobilising resources.

Communities map out their strengths in each of the areas using a so-called River Diagram and update changes over time. Communities also map out their current levels of competence and their desired levels of change in particular practices onto a Stairs Diagram, which can be shared between different communities.

To enable systematic and timely information exchange, communities are connected through an electronic (Internet) workspace in Yahoo! moderated by The Constellation. There is also an UNAIDS-moderated e-workspace meant for all coaches (AIDS and malaria).

## **Caveats and issues**

The observation that the MCC process may have been underfunded, understaffed, and received less management attention than comparable projects in ACC was heard repeatedly during the evaluation process. Several steps that The Constellation recognises as key to the successful management and implementation of a community competence process were omitted, and may reflect in a shortfall in progress towards MCC goals, oversight, and guidance, and the successful completion of community engagement processes. Given this context, the MCC effort will be taken as incomplete at the time of evaluation, to make space for progress that may take place if additional funding is found. The document will be described as a mid-term evaluation.

The data available on the progress of different communities in participating countries are also uneven. Community Self Measurement of Change is the primary evaluative mechanism, but it has not been used consistently. Without a separate set of standardised uniform external indicators, it is challenging, if not impossible, to evaluate the impact of the MCC model on communities. Although it is possible that MCC activities could potentially impact the disease prevalence itself, establishing this is beyond the purview of this evaluation, which limits itself to examining the extent to which MCC activities strengthened ongoing malaria programmes, and engaged and strengthened communities.

## **Country selection process**

This evaluation examines the MCC model's results in three countries—The Gambia and Sierra Leone, which are implementing MCC activities vigorously, and Kenya, where the approach has made limited progress—to suggest answers to the following questions:

- What evidence is there to suggest that the MCC approach is contributing to the impact, efficiency, and effectiveness of ongoing malaria programmes?
- What is the contribution of networking and cross-community knowledge sharing between MCC participants in improving the quality and impact of malaria programmes?
- What observations suggest that the MCC model is having an effect on the community's sense of participation in and ownership of its malaria problem and solutions?



- What MCC resources, processes, and programming seem to be working well? What shortcomings in resources, processes, or programming could be addressed and thus lead to better outcomes?

## Country selection process

The MCC approach that was kicked off in July 2005 with a workshop in Mombasa was attended by nominated participants from nine African countries that have strong malaria control activities and government involvement, in addition to Cambodia. The African countries consisted of Benin, Cameroon, The Gambia, Kenya, Nigeria, Democratic Republic of the Congo (DRC), Sierra Leone, Tanzania, and Uganda (Table 1).

**Table 1. Participants in Mombasa workshop**

Country	Participants
Benin	Dr Petas Akogbeto, Medical Officer (malaria), NMCP
	Mrs Alice Guidigbohoun, Social Worker, NMCP
Cameroon	Mr Dominique Kondji Kondji , Director, BCH Africa
	Dr Emmanuel Forlack Allo, Regional Coordinator for the East Province, NMCP
DRC	Dr John Gikapa a Gudijiga, SANRU III
The Gambia	Mrs Adama Jagne Sonko, Deputy Programme Manager, NMCP
	Ms Marie Chorr, Regional Coordinator, Peer Health Education Project, Nova Scotia Gambia Association
Kenya	Mrs Mary Okech, Social Service/Gender Department, Government of Kenya
	Mr Onesmus Mlewa, Aga Khan Health Services, Kenya, Community Health Department
	Mr John Omoro, Kenya Ministry of Health, Department of Malaria Control
Nigeria	Mrs Janet Martins Offiong, Health Officer, Nigerian Red Cross
Sierra Leone	Mr Joseph Senesie, Health Programme Manager, World Vision
	Mr Wani Lahai, Advocacy/IEC Coordinator, Malaria Control Programme
Tanzania	Mr Clement Chacha, School of Hygiene
Uganda	Mrs Caroline Gumoshabe, Programme Manager, ARISE

The training also included three Constellation coaches who also serve as ACC coordinators in the countries of Guinea Conakry, Togo, and Rwanda. These coaches were already carrying out community competence activities in their countries and had been previously sensitised on the community competence process and tools. In one case (Rwanda), the coach did not become involved in MCC activities at any stage after the Mombasa workshop. For these reasons, these three countries are excluded from the evaluation, and therefore are not profiled in this report.

The current evaluation will be conducted in three countries out of those nine, with two representing settings in which the MCC approach has moved forward and resulted in activities at the community level, and one representing a setting in which MCC has not really taken off in any significant way. The selection is the result of a cross-country comparison based on the following five criteria:

1. Does the country have a strong antimalaria programme and activities at the government and civil society level?

While it is difficult to evaluate this effectively outside of the country using information gathered from the web, one measure to assess this is the country's ability to win repeated Global Fund to Fight AIDS, Tuberculosis and Malaria) GFATM grants, and their scorecard measurements on their performance in spending these funds and accounting for the spending. Much of the background on malaria activities and partners in this evaluation is directly lifted from the GFATM proposals, among other sources.

2. Have MCC-related activities been started and sustained at the project and community levels?

These data were collected from the trained MCC facilitators for each country within the past six months of this report.

3. Is the facilitator based in the country of interest and part of an organisation with a mandate to undertake community or malaria control programmes?

Individuals/countries who attended the Mombasa 2005 workshop as AIDS Constellation coaches and who were then invited to become trained on malaria competence were not included in this evaluation. These individuals had not been selected by RBM to attend but were rather sponsored by The Constellation themselves, and were already familiar with the concepts and processes of community competence. They were already carrying out AIDS competence activities in their countries, and are therefore not comparable to other newly-trained coordinators.

4. Have the country's MCC participants contributed to and participated in the Internet-based network?

The pattern and content of individual contributions to the Yahoo!-based group that was moderated by The Constellation as part of their contract was tabulated and analysed. This evaluation does not take into account any conversations that may have taken place between Mombasa-trained facilitators at the UNAIDS-moderated e-platform for coaches.

The analysis in this document recognises that sharing of practices and lessons occurs through a variety of channels and platforms, and that the Yahoo! e-forum <http://health.groups.yahoo.com/group/malariacompetence> is only one of them. However, because electronic sharing is described as a key component of the MCC process, and was specifically asked for and funded by RBM/Sanofi-Aventis, it is being included as a criterion.

After the June 2005 Mombasa workshop, participants continued their interactions throughout 2005, 2006, and to a lesser extent, 2007 and 2008, using a Yahoo! discussion forum built around MCC and moderated by The Constellation. The group exchanged plans and experiences in scaling up the approach in their countries. A few colleagues, also from other countries, joined the platform.

The Yahoo! platform served as the connecting tool for this community, and consists of an email-enabled discussion group, a document library, and a picture gallery. Most members follow the discussion and contribute to it through the email function of the platform. The discussion is mainly in English, though some contribute in French or a combination of the two languages. Table 2 gives the number of messages sent through the Yahoo! e-group by month and year.

**Table 2. Messages sent through Yahoo! e-group**

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2008		8	1	1								
2007	6	3	1		4				7	3		
2006	25	13	22	15	2	1	13	14	13		11	9
2005							4	50	31	29	35	37

As is evident from the table above, most of the exchanges took place in 2005 and early 2006. Participation has tapered off significantly since April 2006.

The content of these messages varies from supporting each others' activities, social messages, requests for help, exchanges on how to facilitate the approach, and exchanges on practices related to malaria (i.e., distribution of bednets).

In a quantitative analysis of the 359 online entries, nearly half of all entries were posted by either Constellation staff based in Thailand (105 entries), or by any one of the five Constellation facilitators who were invited to the Mombasa meeting (75). The other half, roughly 180, came from the nine countries described in this report, plus a few additional entries.

Most of the correspondents were participants in the 2005 meeting; only six participants posted entries to the group who did not attend that meeting.

Looking at non-Constellation facilitators from the nine countries listed in this report, the most active countries, in order from most to least, included The Gambia, Benin, and Sierra Leone. The DRC, Uganda, and Nigeria did not participate at all in the group. Constellation coaches from Sierra Leone (Ibrahim

Kamara) and from Guinea (Idrissa Souare) were also quite active, with 36 and 20 postings, respectively.

Postings have tapered off dramatically in 2008.

Is there geographic/cultural variation among the selected countries which would allow one to evaluate the implementation (or lack thereof) of MCC activities in a variety of settings?

It would be important to select three countries which are located in different parts of the continent and have a variety of malaria settings and levels of community involvement to examine.

Table 3 presents the summary of the progress and status reports for each of the nine countries considered for evaluation matched against the eligibility criteria for qualifying as an evaluation site.

**Table 3. Progress and status reports**

	Benin	Cameroon	DRC	The Gambia	Kenya	Nigeria	Sierra Leone	Tanzania	Uganda
Strong/adequate national programme	YES	NO	NO	YES	NO	NO	NO	YES	YES
MCC activities taking place	YES	NO	NO	YES	NO	NO	YES	?NO	NO
Facilitator part of a malaria organisation	YES	?YES	YES	YES	YES	YES	YES	?NO	?NO
No. of Yahoo! group postings by facilitator	22	19	0	34	18	0	24	8	0
Region/language	W/ Fr	W/ Fr	C/ Fr	W/ Eng	E/ Eng	W/ Eng	W/ Eng	E/ Swa/ Eng	E/ Eng

Using these criteria and examining the nine countries, it would seem that the best choices for the evaluation are The Gambia and Benin or Sierra Leone for MCC-performing countries, and Kenya as the nonperforming country. As no French speaker was available to perform the evaluation, Sierra Leone was chosen.

## Management and administration

The idea of extending the ACC process to malaria grew out of the positive experiences and results coming from stimulating local responses to AIDS in Thailand and elsewhere. Prof Awa Marie Coll-Seck, who returned from a stint as health minister in Senegal to head the RBM Partnership in 2004, was already familiar with the rationale for community empowerment from her days as director for research and strategy, with UNAIDS in the late 1990s. The concept of ACC was just being articulated in Phayao, Thailand. The study done there

had shown that community strengths and initiative could play a decisive role in altering the course of the AIDS epidemic.

Support for extending the concept of community competence to malaria grew out of several presentations sharing the findings of the ACC process. The first of these was by Dr Jean-Louis Lamboray, then with UNAIDS, to officials of the RBM Partnership. The next presentation was made at Health for Peace, a meeting of health ministers from eight West African countries (Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Senegal, Sierra Leone, and The Gambia) in Banjul from 20 to 22 June 2005. They adopted a short-term action plan in support of accelerating implementation of malaria control in their countries (see Banjul Declaration and Action Plan). The central element of this regional plan was the efficient and effective sharing and learning of lessons emanating from experiences in scaling-up national malaria control. With facilitation from The Constellation for AIDS Competence, health experts self-assessed their countries' competence with regard to 14 RBM key practices. They then compared notes with their peers in order to identify good practices for sharing. Participants also got the opportunity to observe a self-assessment process being facilitated with members of a community in Banjul. As it became increasingly apparent that the MCC process was being seen as interesting and worth trying by key stakeholders both in the RBM Partnership and in a handful of West African countries, the RBM Partnership invited a set of countries to the Mombasa workshop near the end of July.

In August 2004, Dr Lamboray left UNAIDS and became full-time chair of The Constellation for AIDS Competence, the Belgium-based NGO which had developed the ACC approach. The task of launching the MCC model with a workshop in Mombasa was contracted by RBM to The Constellation. The contract specified the following deliverables:

1. Train two to five facilitators from five countries selected by RBM, and a maximum of ten additional participants from the various constituencies of RBM.
2. Provide distance coaching to the country participants upon their return to their country.
3. Assign one coach per country for individual follow-up by email and telephone.
4. Set up an e-workspace to support the exchange of experience prior to the Yaounde meeting.
5. Facilitate a one-day workshop on the day prior to the Yaounde forum, for all participating countries to attend.

The pharmaceutical company of Sanofi-Aventis directly paid The Constellation the sum of €72,000 (about US\$ 90,979) for these tasks. The contract does not specify a time frame for the activities, and it does not indicate how long-distance coaching is to be provided to participants.

According to The Constellation, the level of funding made available was inadequate for successfully implementing a process of building community competence in malaria in 12 countries. As a comparison, the funding used to

develop ACC in three provinces of Mozambique over a 12-month period was €130,178 (roughly US\$ 156,000). Less than three-fifths of this amount was made available to develop MCC in 12 countries over a period of roughly two years.

The Constellation's own subsequent proposals to the RBM Secretariat sought additional funding in 2006 for activities mentioned in the contract.

In 2005 we have learned that support from an external coach to each individual country is a crucial aspect for successful implementation. The Constellation will assign one coach per country who will support the process via long-distance media (email, telephone, Skype, videoconferencing). The coach would bring two country visits of one week each per year to help the countries in the process.

Costs: Coaching Services Constellation (individual long-distance learning for 12 months; two country visits) €30,000 (about US\$ 36,000) per country.

Some other activities proposed by The Constellation were five-day regional learning and sharing events (€60,000 or US\$ 72,000 each) and three-day knowledge fairs (€90,000 or US\$ 108,000 each).

Judging from the funding sought for each separate activity, it would appear that the amount of funding made available for the MCC rollout was seriously inadequate for the support necessary to create sustainable community competence in malaria across 12 countries.

"The difference between what we would have wanted and what we got is immense," said Dr Lamboray. "We were unable to apply the practices we were recommending because of lack of funding. We could not guarantee that quality. We don't think it is the correct way—to train people in Mombasa and then say now go and do it yourselves."

One practice missing from the MCC process that has a direct bearing on the quality of facilitation at the community level is mentoring, or "accompaniment," as The Constellation officials call it. "We think it is necessary for coaches to accompany facilitators to the community. The facilitators' practice is continually improved with accompaniment by the coaches."

This "accompaniment" or mentoring was a key activity in the ACC process that was missing from the MCC process. In its absence, there was no reliable way to monitor the quality of MCC processes conducted at the community level, counter the dilution of content and skills as these filtered down from the coaches to the community, or support the communities in developing a uniform framework of evaluation indicators. As a result, The Constellation's capacity to ensure high-quality results in the participating countries and communities is impaired. From the point of view of this evaluation, it has meant that making comparisons across countries has been impeded by scanty and uneven data, nonstandard parameters, and irregular reporting of progress.

The MCC project is also notably characterised by a lack of centralised management responsibility. As a result, there is an absence of long-term management goals and corresponding management structure. Judging from



interviews, The Constellation's participation over the years between 2005 and 2007 reflects more a certain level of personal commitment among its members than a properly funded and managed MCC initiative. The staffing of the MCC project at The Constellation level—one part-time official for management, administration, and moderation of the Yahoo! Group—reflects their turnkey contract, which required only five discreet activities. Significantly, the deliverables did not include ensuring a successful rollout of the MCC process across the participating countries and communities. An observer might be forgiven for concluding that the MCC project's core assumption was that community competence in malaria could be achieved across a dozen countries through one training workshop, a follow-up workshop, a moderated e-workspace, and distance support through email and phone.

This evaluation is mindful of these limitations and aware that a deeper involvement of The Constellation's staff and coaches would possibly have yielded a completely different set of outcomes. Apparent progress in malaria-control activities at the community level could reflect the effectiveness of MCC facilitators, tools, and processes as easily as the individual commitment of officials already involved in malaria control.

## Facilitation processes and tools

The processes of building community competence in a disease condition ride on a philosophy of respect for the community's capacity to address its own problems, as well as a set of systematic processes that enable dialogue, analysis, planning, sharing, and evaluation.

The processes and tools used are:

1. Support to action learning and transfer (SALT) visits, which take place at the initial stages of interaction with the community. A "community" in this context may consist of members of an organisation, groups, or networks with whom an organisation works. SALT visits are characterised by enquiry, listening, appreciation of community strengths, and when successful, create interest and commitment to deeper engagement at the community level.
2. Facilitation of self assessment by "communities." The self-assessment process offers a framework for evaluating community strengths, gaps, and needs against a 14-point framework of malaria competence. In a successful self-assessment process, communities begin talking about malaria, the role it plays in their lives, their capacity to deal with it, and their needs and resources. The result is a priority list and a plan of action. Tools used: Self-assessment framework.

Other tools used in self assessment and planning are the River Diagram and the Stairs Diagram. The River Diagram provides a graphic representation of the relative progress of different communities. The Stairs Diagram identifies those strong communities that can provide or share certain strengths.

3. Support for Self Measurement of Change (SMoC): This process provides a tabular framework to help communities evaluate performance against targets. Tools used: Self Measurement of Change form.

4. Support for knowledge fairs, where communities exchange lessons learned from experience.
5. Support for the development of KAs, which summarise common principles for action based on experiences and available resources for those who wish to adapt those principles to their own context.

Based on interviews with coaches and facilitators in The Gambia, Sierra Leone, and Kenya, the processes and tools listed most frequently deployed by facilitators with the MCC process appear to be self assessments. The River Diagram was used to a lesser extent, partly because it needs to be generated on a computer, and the Stairs Diagram was not mentioned in interviews as a commonly used tool.

In general, all facilitators interviewed said that the MCC approach has worked well to empower communities to participate in malaria control. Anna Haffner (The Gambia) has successfully used MCC processes with urban women's groups and civil society organisations. She said that it works well with community groups of similar educational and economic backgrounds, and she thinks it would be difficult to use the approach with people from the upper social classes.

Before he underwent training in the MCC process, Balla Kandeh had not believed that communities were capable of setting targets and making plans for malaria control. Now that he has seen communities taking charge after conducting self assessments, he believes that MCC processes are essential to the sustainability of the malaria control programme's efforts to build community capacity to tackle malaria.

## **Self-assessment tool**

The self-assessment tool stood out as the most powerful one in the MCC toolkit. While the other tools essentially help communities structure and analyse data about themselves, the self-assessment framework generates new data and understanding based on an introspective process, and helps participants to develop action plans based on their insights and priorities. Not surprisingly, all facilitators found this tool very useful in enabling communities to take charge of their own malaria control programme, identify their own needs, and make their own plans.

Facilitators in Sierra Leone commented that the self-assessment tool can easily be adapted for use with other development issues. Ibrahim Kamara has developed a community health competence tool and a child health competence tool, and used them with a couple of communities to help them identify issues and make action plans.

Below are some of the observations facilitators made about this tool:

It is generally easy to use, but complicated for low-literacy audiences. In general, facilitators found that it takes longer when used with less-educated groups, and is conceptually difficult for participants to understand. Facilitators in Sierra Leone pointed out that the self-assessment tool uses several terms which are difficult to translate to the local language, and even when translated, are difficult for less-educated people to understand. For this reason, some facilitators have used the tool only with educated people.

Some of the issues on the self-assessment framework, such as gender, are not well understood by community members, and yet gender roles and relationships affect ITN use by children and pregnant women, and even access to early and appropriate treatment among children.

It can be used for monitoring and evaluation, particularly when the assessments are documented and repeated on a regular basis.

Its success depends on a high level of facilitation skills. Although the steps of the self-assessment process seem linear and mechanical, its ability to inspire and motivate independent community engagement and sustained action depends on the quality of facilitation. This observation points to a central characteristic of the community competence approach—it is not a cookie cutter that may be applied from a reading of a manual. Officials of The Constellation working on MCC stress that it does “require some strategic shift in mindset from interventionism towards facilitating local responses.” They emphasise that the tools are useless unless applied with the correct values, namely the focus on strengths and the confidence in the community’s capacity to respond.

The need for skilled facilitators was pointed out as a weakness of the self-assessment process. The reliance on external facilitators for conducting assessments, and the fact that communities have not yet been able to conduct repeat assessments on their own, are both listed as disempowering factors that increase the community’s dependence on external resources.

It brings out areas where groups need more information. An unexpected dimension of the self-assessment tool is its effectiveness as a tool for identifying information needs and addressing them. The framework for self assessment introduces many technical terms during the discussion on assessment parameters, sometimes in English, that are new to the community. The process of self assessment invariably involves negotiating equivalents in the local language, and defining the terms where necessary. Thus, self assessment ends up being a learning process that raises the technical mastery of the participants.

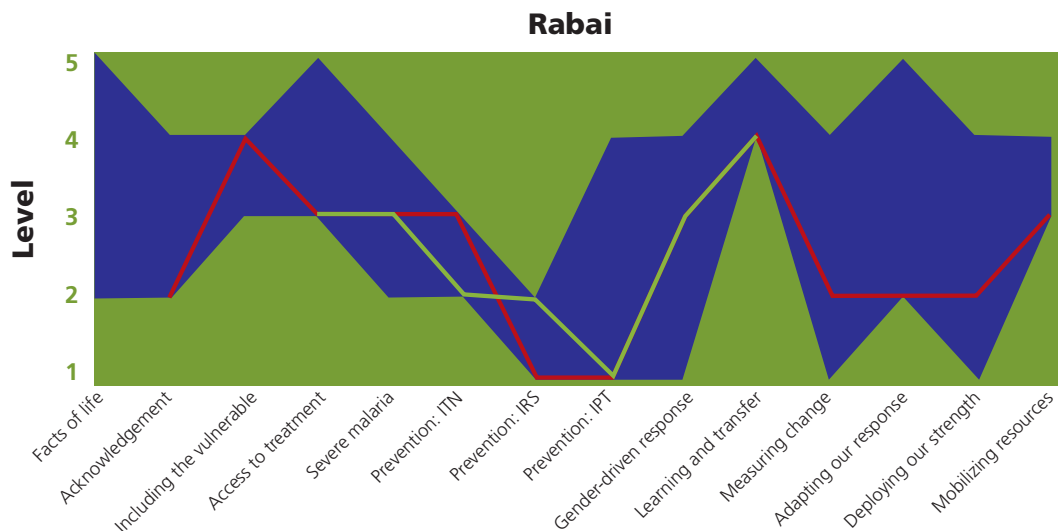
Not surprisingly, this emerged obliquely in several focus groups and interviews, where people attributed increased knowledge of malaria to the self-assessment process. One facilitator uses it to structure health education talks. When the tool is used on one specific area, such as ITNs, treatment of malaria, and IPT, it helps to identify areas where groups need more information.

It is seen as complicated for some communities. Onesmus Mlewa, Kenya-based coach of The Constellation who works with Population Services International feels that even a concept like self assessment may be alien and abstract to communities. He finds the “dream” concept more realistic. “What is your dream?” A person’s dream may be to see their children live to see their fifth birthday. “How do you want to realise this dream? Where are you in realising your dream?” The word “dream” translates the self-assessment concept into language that communities can relate to. Once people have described their dreams, then they can set targets for reaching them.”

It is flexible. It builds on the community’s existing knowledge and can be a means of updating a group’s understanding about malaria.

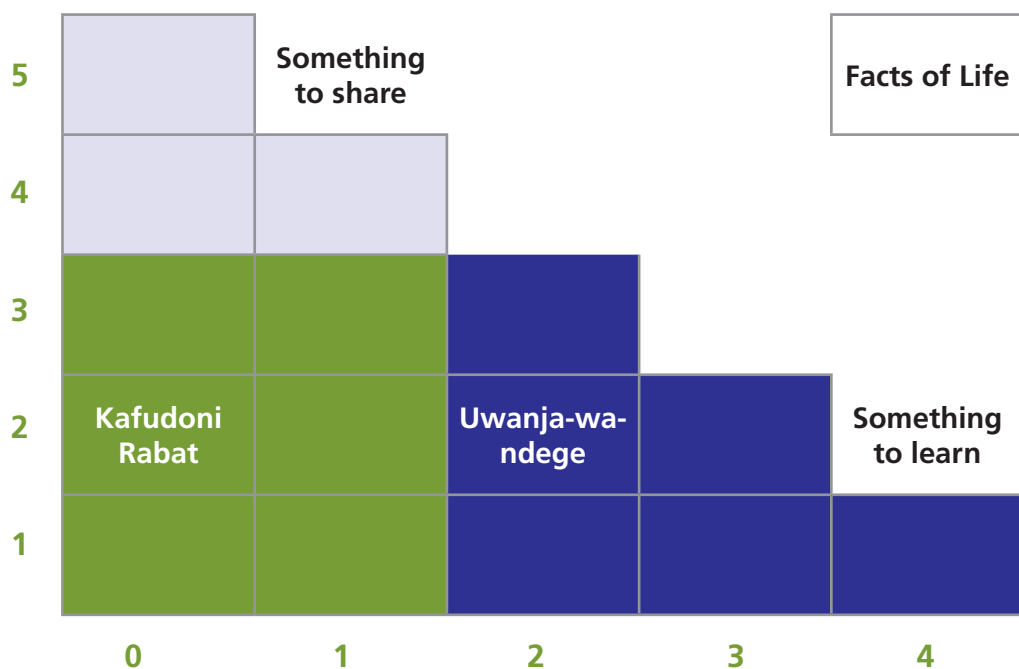
## River Diagram

This tool was not used directly with community groups. Since the River Diagram must be generated on a computer, facilitators take information back to their offices to make the diagrams. The diagrams were generally not shared back with the community groups but typically with central- and regional-level groups. Some facilitators found the River Diagram too complicated, and at least one preferred to make his manually rather than on a computer.



## Stairs Diagram

The Stairs Diagram is used to help community groups identify learning needs, and also to find where they can draw that expertise or learning from. Marie Chorr in The Gambia said that she uses this tool with all the community groups she works with. Only one facilitator in Sierra Leone used this tool.



## Self measurement of change (SMoC)

The SMoC tool is an aid for communities to assess progress on planned antimalaria activities in an informal way rather than a rigorous evaluation tool. The version of the SMoC tool posted at the Yahoo! forum was clearly a copy of the ACC SMoC tool, since the word AIDS had not been replaced with malaria; furthermore, data from reports and interviews with facilitators and coaches do not indicate whether or how much communities used the SMoC tool. The tool (see Table 4) reflects The Constellation's perspective that the most meaningful evaluation is the one that the community does of its own plans, activities, and progress. The last column (How would someone else verify our assessment?) provides a stimulus for the community to explore an external perspective, but this is the closest the framework gets to an external point of view.

Table 4. Self measurement of change tool

Priority practice for malaria	Current level	Target level	Actions to meet target	How shall we know that we are progressing?	How would someone else verify our assessment?
			•	•	•
			•	•	•
			•	•	•

The page of the ACC website featuring the SMoC is prefaced by this brief rationale:

The primary function of measurement is to benefit and to motivate those who are doing the measurement, the community themselves. It should not be focused on demonstrating the validity of the approach to external parties.

However, within The Constellation, there seems to be a growing awareness of the need for credible and convincing evidence of the effectiveness of the community competence approach that is acceptable to other governments and external agencies.

“Community SMoC was a challenge,” says Marlou de Rouw, manager and founding member with The Constellation. “We recognise that we need some more thinking on this. SMoC is not enough by itself to generate hard-core evidence of the kind that is needed. The pressure that RBM works under is also a challenge to us. Community involvement is not part of their mainstream thinking. There is a feeling like yes, we should do something with community, but it's easier to do bednets or a trip up the river. We see that we need to have some external way to assess, beyond the SMoC.”

A specific deficiency of the MCC process may be the lack of standardised outcome indicators that could permit comparisons of the process across different country settings. Dr Lamboret attributes this to the low level of funding. “If coaches had been able to accompany facilitators in their interactions with the community, I can guarantee that a standardised framework of indicators would have evolved,” he says.

The challenge facing community competence is a paradox: how can external evaluation be conducted in a way that it is driven and led by the community? Ian Campbell of the Salvation Army, who sits on the board of The Constellation, captures this challenge memorably in an email discussion:

Keep the idea of “measurement” going but consider the fact that a human capacity for response/AIDS competence, vision, and approach cannot be adequately evaluated externally and quantitatively. It needs a qualitative and semiquantitative approach from the beginning that is shared with communities and driven by them. It must be shared in terms of implementation and planning and understanding. It must be owned by the communities and NGOs. It must not happen before actual sustained work and outcomes are happening in terms of both local response expansion—a core indicator—and organizational adaptation . . . It needs time and consultation to do this well. The primary goal now must not be to prove anything to skeptics—that may come but it is later.

## Knowledge assets (KAs)

The KA is a form of written documentation that presents useful principles or practices related to a specific activity (such as facilitating a self assessment), describes actual experiences illustrating that principle, and cites references to individuals who could share information in greater detail (Table 5).

Table 5. Knowledge assets tool

Common principle	Experience	Reference
Build a relationship with the community	In Rwanda and Congo, members of the national facilitation team bring a SALT visit to a community where they appreciate the strength of the community and introduce the self assessment	Prince Bosco Kanani, Rwanda bosprince@yahoo.fr Judith Dialundua, DRC (email address) Doc: SALT visit process note
Familiarise yourself with the tool, know the practices by heart, and be able to play with them to suit the situation	In India, the community members became tired of sitting and discussing, so the facilitators changed their approach. The self assessment became more interactive, with the 5 levels positioned around the room. The community suggested that using this approach was more interesting and something they could do with each other independently	Claire Campbell, Australia (cbcbell@aol.com) Luc Barriere-Constantin, Switzerland (luc@aidscompetence.com)



The Yahoo! forum lists about 15 KAs, covering areas such as global and regional advocacy, demand creation and effective use, strengthening delivery systems, ITNs, access to treatment, IPT, and vulnerable groups. However, these were created mainly in the years 2005 and 2006, and possibly reflect work done during The Constellation's contractual commitment.

More significantly, KAs are expert compilations, reflecting both access to a wide spectrum of experiences and sources, and a strong programmatic perspective. In their current format, they encapsulate the best of collective experiences and provide the stimulus for networking and conversations. However, their regular creation presupposes an efficient system of feedback and communication between communities (including organisations, groups, and networks) and a centralised compiling authority, such as The Constellation.

There is insufficient evidence available for analysing what effect, if any, KAs have had on the MCC process. Accessing them calls for a level of individual initiative, Internet access, and enough urgency to seek out further conversations to follow up on the pithy principles and experiences laid out in the KA. Several facilitators have mentioned poor Internet access as being a barrier.

The perspective of sustainability of the MCC process raises a question: to what extent can the expertise for creating KAs be created within the community, at the level of individual organisations, networks such as Red Cross or the Nova Scotia Gambia Association, and community groups? A community's ability to do this would hinge on several subskills, including:

- Having access to a wider body of similar experience and practitioners.
- Identifying a practice or intervention as a better practice, worth sharing.
- Perceiving an advantage or need to share the practice with others.
- Documenting the skill in a user-friendly manner that makes it teachable.
- Having access to and control over a dissemination network and resources.

At the moment, there is no evidence that KA creation is a skill disseminated at the grassroots community level. As mentioned earlier, the conversation threads in the Yahoo! forum did not focus on specific knowledge or practices, but remained at the level of supportive social exchanges.

## **Knowledge fairs**

"We made a proposal to bring people together in knowledge fairs, but funding didn't come through. So no knowledge fairs yet," said Marlou de Rouw. At the meeting that was held in Yaounde six months after the Mombasa workshop to review progress on MCC, and attended by coaches and facilitators, there was a sharing of experiences and practices in an event that has been described as a knowledge fair. "There were 11 rooms, each one showcasing one successful practice," said Gaston Schmitz, The Constellation's official in charge of facilitation and transfer.

In May 2008, the ministry of health (MoH) conducted a knowledge fair for all the schools involved in the initiative to share the learnings from a peer health

education (PHE) programme started a year earlier in 30 schools with the Nova Scotia Sierra Leone Association. Each school conducted a self assessment, set targets, made plans, and started activities. This project was so successful that the MoH has included an expansion to other schools and communities in the Global Fund Round 7 application.

## Quality of facilitation

Creating MCC may be thought of as a process with four tiers—creating facilitation skills, generating community data, developing community action plans, and measuring change (See Table 6). Facilitation skills are developed within organisations and networks that work with the community, and consist of skills in administering MCC processes. This has several outcomes, all of which may be thought of as generating community data and insights, which include heightened awareness; increased technical knowledge of malaria; a community-led assessment of community strengths, weakness, and gaps vis a vis malaria; and a prioritisation of needs. As self-understanding deepens, options emerge and communities develop action plans against malaria. As these plans are implemented, communities carry out self measurement of change to evaluate progress.

Table 6. Creation of Malaria Community Competence

Nature of activity	Who participates	Who facilitates	Outcomes
Creating skills in facilitating MCC processes such as self assessment	Nominated facilitators from government malaria programmes, and networks and organisations that work with the community	Coaches from The Constellation	Skills in administering MCC processes
	Selected facilitators from local NGOs and CBOs	Facilitators trained in the previous step	Skills in administering MCC processes
Facilitating community self assessments	Community groups	Facilitators trained in the two previous steps	Community data and insights
Developing action plans based on priorities	Community groups	Facilitators trained in the two previous steps	Action plans against malaria
Self measurement of change	Community groups	Facilitators trained in the two previous steps	Evaluation reports

The process is characterised by a few Constellation coaches at the first tier who develop skills among a larger number of facilitators nominated from government malaria programmes and networks and organisations that work with the community. These facilitators, in turn, pass on the skills to a larger number of facilitators drawn from community-level NGOs and CBOs. At the last tier is the community, arguably the largest of all these groups. This exponential process in which skills are multiplied from a few to the many may be thought of as a typical cascade. It is usual to see loss of quality and information in any such process of diffusion. However, a community competence process cannot afford dilution. High-quality facilitation in interactions with the community (in the last tier) is crucial to successful outcomes within the community. What mechanisms exist for fighting dilution? Were those mechanisms deployed in the current project?

In the sections that follow, coaches refers to members of The Constellation's informal network of trainers in Africa (and Asia) who have mastered the various community competence tools and processes, and share a common belief in the power of the community to address its predicaments and develop solutions that work for them. The word facilitators will refer to individuals from the government malaria programmes and from international agencies who have been trained by coaches. Individuals from community-level agencies who have been trained by facilitators will also be referred to as facilitators. The community includes political, social, geographical, and cultural groupings that get together to implement the ACP within different geographical boundaries. This includes business networks, civil society, villages, local authorities, health networks, professional organisations, and stakeholder groupings, among others.

How are coaches identified and trained? The Constellation's global network of coaches constitutes a unique institutional resource that seems to play a central role in the success or failure of community competence initiatives. At the time of this evaluation, The Constellation had a network of 47 coaches operating within organisations in 21 countries in Africa, Asia, and Europe. This included the 12 founding members of The Constellation. Except for these, coaches are not employees of The Constellation, but operate more like a guild, or a community of practice, linked by a shared philosophy and set of values oriented towards the primacy, wisdom, and innate strength of the community. The following words from The Constellation's website indicate some components of this shared belief system:

... [This] global network of coaches and facilitators ... promote[s] "the other way"... Coaches don't see themselves as "experts." They do not seek to organize resources. Rather, they stimulate responses by appreciating people's strengths and by learning from what they do. In this way ... competence spreads: people care, they connect to others, they change and they transfer their experiences to other groups and organizations. ... To become a coach, you do not need a diploma or a specific status. However, you need to show a positive learning attitude and facilitation skills. Two existing coaches will invite you to become a coach, once they have seen you facilitate.

Coaches network by phone and email but also informally, taking advantage of regional events and workshops. Several of them are sought out to facilitate community competence by projects in other countries. For instance, Onesmus Mlewa, a coach in Kenya, who was nominated by Marlou de Rouw of The Constellation, and endorsed by Jean-Louis Lamboray, was invited to Papua New Guinea to facilitate the ACC process there.

Ibrahim also visited Cameroon to train 11 plan partner staff in MCC. Joseph has given a presentation in South Africa for World Vision health coordinators in Africa about MCC, and subsequently received a request for assistance from the Mali office. The Constellation linked them up with a MCC coach living in Mali.

In all the interviews conducted with The Constellation's coaches during the course of this evaluation, there was clear evidence of their strong sense of commitment, community, shared purpose, and initiative. In a few cases, the coaches seemed to feel greater allegiance to The Constellation than to their employing organisations.

What is the vision of the community that coaches share with The Constellation? The spirit seems to be expressed succinctly in this quotation from an interview with Dr Lamboray:

. . . Once people start discussing the issue, acting on the roots of the issue in their setting, enabling everyone to live their potential, then you see progress. . . There needs to be the facilitation of local responses to AIDS. And that is . . . done not by telling people they have a problem but rather by appreciating their strengths, what they can do by themselves to deal with the issue. . .

How does The Constellation identify individuals who share this vision of the community, embody it in their facilitation of community interactions, and possess the skills to energise communities with this vision? The Constellation has no documented process or statement that lays down the process of recruitment. There seems to be a large measure of highly skilled subjective judgement in the identification and nomination process, a spirit of "It takes one to know one." The only visible formal check or balance visible in the process is the institutional requirement for an independent endorsement by a second coach when someone is proposed as a coach.

Coaches are encouraged to use a 20-point self-assessment form in evaluating how well they are doing as coaches. The Constellation does not directly finance networking among coaches, instead encouraging them to use the e-space—a website moderated by UNAIDS and used by coaches as a networking and sharing platform—as well as take advantage of fortuitous opportunities afforded by regional meetings and workshops. There is a surprising amount of such interaction between The Constellation's coaches, a measure of the sustainability of what is essentially a self-motivated and voluntary process.

"I have learned different modes of facilitation by my interactions with other coaches," says Onesmus Mlewa, a coach in Kenya. "How to listen more proactively, how to encourage people to say what they want to. Clare Campbell is very good at this, and so is Jean Louis. Inspiring stories from other facilitators help us to gradually understand the community competence process better. For

example, the introduction of the ‘dream’ concept opened up my mind to focus differently on self assessment. I saw it more realistically and then it became easier to explain.”

Selection process of facilitators for the Mombasa workshop: It was equally challenging to get a clear articulation or written statement of the criteria used for selecting participants to the Mombasa workshop. According to Boi-Betty Udom, RBM’s technical officer for country support development, who was closely involved in the selection process, possessing communication skills was the main requirement, but it remains unclear how communication skills were defined or identified. Primary responsibility for identifying participants with “communication skills” was left to the participating countries’ NMCPs and large NGOs.

“Once the countries made their choices, I looked at the CVs of the participants to see who was the best fit,” said Boi-Betty Udom. This vetting represents an interesting departure from standard practice in many workshops, where government nominees are accepted without scrutiny even if they are not appropriate. “About 90% turned out to be what we wanted. Kenya sent three people, and we were not quite satisfied with those. But Kenya was the host country, so we could not reject their nominees. Another disappointment was Uganda. There were two people from there, and during the workshop, I wasn’t convinced they could go back to the community and do what had to be done.”

Boi-Betty admits that this could be a weak link. “I feel we should do interviews with country participants,” she says. “Some countries might want to impose a particular person and that would not be in our best interests.”

The absence of clearly articulated guidelines for identifying, recruiting, and training high-calibre coaches could be a serious impediment to wider global practice of the community competence process. Scaling up in the long term would require unambiguous guidance on how coaches and facilitators should be identified, currently a driving and unique strength of The Constellation that still awaits rigorous documentation. Without this sharing, it is nearly impossible for any organisation but The Constellation to implement a community competence process.

The Mombasa workshop was facilitated by a panel of coaches drawn from The Constellation’s Africa-wide coaches network that was already propagating ACC processes within their settings. Some of the participants trained as MCC facilitators in Mombasa, such as Joseph Senesie in Sierra Leone, and Marie Chorr in The Gambia, have now become coaches of The Constellation. Joseph Senesie identified David Kpevai, also with World Vision, as a potential coach. Ibrahim Kamara, a long-time coach from Sierra Leone, observed David in facilitation, and endorsed the recommendation.

## Did MCC make a difference?

This section examines evidence on the extent to which the MCC approach has contributed to the impact, efficiency, and effectiveness of ongoing malaria programmes in two of the countries that participated in the project. The two

countries examined are The Gambia and Sierra Leone. Both are situated in West Africa, and stood out in the country analysis as active and inspired players in the MCC process. In this regard, they may represent the apogee of MCC's potential to energise a country's ongoing antimalaria activities. This chapter looks at claimed changes in the two countries, and the extent to which they could verifiably be attributed to MCC activities.

## **The Gambia**

In The Gambia, malaria is one of the leading causes of morbidity and mortality, especially among children under five years. Twenty percent of antenatal consultations and 40% of under-five outpatient visits were due to malaria, according to a malaria situation analysis conducted by the NMCP in 2000.

In 2001, the government developed a malaria policy and in 2002 developed its five-year Malaria Strategic Plan 2002–2007. This year, 2008, it is developing its next five-year plan. Key programme areas outlined in the malaria policy include malaria case management; prevention and control of malaria in pregnancy through ITNs and IPT with sulfadoxine-pyrimethamine (SP) twice during pregnancy; vector control through ITN use, larviciding, environmental management, and IRS, which is being introduced in June 2008; social mobilisation, communication, and partnerships; and surveillance, monitoring, and evaluation.

Since 1999, The Gambia has registered continuous declines in malaria cases as measured by malaria-positive microscopy, the largest decline occurring between 2000 and 2004. There has also been a decline in diagnosed cases of malaria in pregnancy between 2003 and 2005, during which time the prevalence was cut by approximately 75%. The NMCP attributes these declines to increased use of ITNs, increased uptake of IPT during pregnancy, and intensive social mobilisation targeting male community leaders and women. This scale-up was made possibly through support from GFATM Rounds 3 and 6, involvement of partners, improved access to drugs and other malaria-related services, and increased community involvement and participation.

The NMCP receives funding through Global Fund, The Gambia's government, UNICEF, WHO, and other in-country partners. NSGA is a major partner with NMCP for community mobilisation.

The MCC approach was introduced in The Gambia after the Mombasa workshop. It is not possible to assess what contribution the approach has made toward the downward trends in malaria morbidity in The Gambia, as the decline was already well underway when the approach was introduced and no empirical studies have been done to evaluate the effects of the approach independent of other interventions. As Ms Adama Jagne Sonko of the NMCP stated, "we cannot attribute the decline in malaria morbidity to one intervention alone. It has resulted from the combined efforts of many fronts." Nonetheless, the NMCP believes that the MCC approach is instrumental in building sustainable community responses to malaria control, and has plans to scale up the approach to all communities in The Gambia.



The NMCP is approaching malaria control through four main strategies:

- IPT with two doses of SP during pregnancy (three doses if the woman is HIV positive).
- Free long-lasting insecticide-treated net (LLIN) distribution to pregnant women and to children under age five during mass distributions and routinely through reproductive and child health clinics.
- Annual mass net retreatment campaigns for conventional nets.
- Treatment through clinical facilities with artemisinin-based combination therapy based on clinical diagnosis and/or laboratory confirmation.

MCC implementation in The Gambia: Two nominees from The Gambia participated in the Mombasa workshop on MCC organised by The Constellation for AIDS Competence July 19 to 22, 2005: Adama Jagne Sonko, Deputy Programme Manager, NMCP, and Marie Chorr, Regional Coordinator, PHE Project, NSGA. During the Mombasa workshop, they conducted a self assessment, set targets, and made an action plan for introducing the MCC approach in The Gambia on their return.

For their action plan, Adama Jagne Sonko and Marie Chorr decided to introduce the MCC approach into an ongoing community-based malaria project implemented by the NMCP, Catholic Relief Services, and NSGA with GFATM Round 3 global funds in the Western Region, which is the largest and most populated region of The Gambia with approximately 60% of the population residing there. The project trains and works with PHEs based in schools, as well as teachers, opinion leaders, women's groups, and local drama groups, to sensitise communities about malaria. The project supplements community-based activities with call-in radio programmes, video shows, short drama performances in busy public venues such as marketplaces, and through print materials (posters and flipcharts).

Adama Jagne Sonko and Marie Chorr first oriented all heads of departments in the NMCP, and all project staff in NSGA to the MCC approach. During this, participants conducted their own self assessment as well as developed a plan of action. Adama Jagne Sonko and Marie Chorr next facilitated training in the MCC approach and a self assessment among the Western Regional Health Team. Following the Western regional action plan developed there, they trained 15 MCC facilitators drawn from multidisciplinary facilitation teams (MDFTs) working in Western Region. Members of MDFTs include teachers, public health officers, journalists, and community health nurses. These local facilitators, once trained in MCC processes, facilitated self assessments in 18 communities in Western Region.

Communities in The Gambia seem to have embraced the MCC approach wholeheartedly. Equally clear, much of the impetus for this has come from Adama Jagne Sonko and Marie Chorr. By the end of 2008, they were able to report that they had trained 63 facilitators countrywide to perform MCC self assessments, effectively scaling up the process of introducing MCC processes to communities.

In their 2008 report, facilitators from The Gambia report that as a result of implementing MCC activities, they have seen changes at national, divisional, and grassroots levels, including:

1. Increased male involvement in malaria prevention in families.
2. Increased local mobilisation of resources.
3. Increased knowledge on malaria prevention and control.
4. Increased partnership, collaboration, and support.

Although progress in The Gambia does appear to be energetic and sustained, closer scrutiny of the details indicates that some claims are better supported than others. For instance, there were clearly community initiatives in the four villages of Kerr Pateh, Njaba Kunda, Kerewan, and Salikenni that led to creative resource mobilisation led by opinion leaders and women's groups as part of an initiative to increase net coverage and usage. Money was raised through:

- Village development committees (VDCs) – Njaba Kunda Village.
- Women's microsavings – Salikenni Village.
- Fundraising activities – Kerr Pateh Village.

The bednets purchased with the money raised were given to vulnerable people in the communities. The activities have increased bednet usage and coverage from 80 to 200 in Kerr Pateh; 100 to 170 in Njaba Kunda; and 250 to 300 in Salikenni. The activity seems to have also inspired other community members.

“Every year I give D2000.00 to the hospital as a donation. This year I will use it to buy bednets for my people. .”

—Alhagie Sainey Kanteh-Alkalo , Salikenni Village

The claim of an increase in male involvement is not supported by available facts, although there may be increased awareness of the need for greater male involvement as a result of several village-level initiatives. These may or may not have led to increased male involvement in those places. In the villages of Njaba Kunda and Illiasa, the MCC self-assessment process led to the formation of village-level committees for increasing men's awareness of the need to take greater responsibility in malaria prevention and control. In the patriarchal social set-up of these villages, men typically saw their roles as stopping at financial support. The village-level committees organised focus group discussions, made presentations in houses and mosques, and so on, urging community men and other influential community ward leaders to play deeper moral and social roles in malaria prevention and control within their families.

“I never knew that men have roles to play in malaria prevention and control. I thought that by providing our wives with money to take the children to the hospital when they are sick, that's enough.”

—Alagie Dibba Jaiteh – Deputy Alkalo (village head)

In the absence of reliable baseline data, it is difficult to credibly claim substantive increases in knowledge of malaria, its prevention, and its control. The government

had conducted a KAP study in these villages, but it is not clear whether a formal evaluation of knowledge against that baseline was conducted.

The self-assessment process led to a surge in community-led initiatives to create greater community awareness around malaria. Interestingly, some of these initiatives built upon ongoing project activities, sometimes introducing malaria-related topics into other ongoing discussions. A few examples:

1. PHEs of Albreda Upper Basic School and Kerr Chernoo Senior Secondary School conducted weekly malaria presentations during antenatal clinics at the health centres for pregnant women and caregivers of children less than five years. The idea was to sensitise pregnant women and caregivers on the importance of early and timely malaria case reporting and treatment, malaria in pregnancy, and the importance of early antenatal bookings for IPT doses, etc. There were similar presentations in schools.
2. In Illiasa Village, opinion leaders, women's group, PHEs, and youth groups collaborated in weekly presentations at antenatal clinics, and nursery schools for children under age five.

The Gambian 2008 report lists results that may be attributed to deepened grassroots community engagement coming out of the MCC process of self assessment, along with results that reflect the leadership and initiative of technical partners in the national malaria response. It may be useful to see these separately—to one side are activities and plans that emerge when the self-assessment process is conducted by project staff; to the other side are activities and plans that evolve when grassroots community groups participate in a self-assessment process with the help of trained facilitators. Making this separation helps view the outcomes of MCC more systematically.

In this case, the NSGA is an important technical partner, and Marie Chorr, regional coordinator of the NSGA, was the MCC facilitator who received training at Mombasa. The 2008 Facilitators' Report from The Gambia includes the two results below, which seem to point towards project leadership rather than grassroots community initiatives. While this does not in any way diminish the outcomes, it may be a demonstration of the personal engagement of the facilitators than community drive. The NSGA has been as deeply involved in the PHE programme as with Drama Troupes, and a collaboration between the two still reflects the workings of the same organisation.

1. PHEs of 15 schools in 15 communities in the North Bank regions of The Gambia collaborated with NSGA's Drama Troupes to conduct bi-weekly presentations on malaria-related issues in all intervention areas where the self-assessment tool had been used. These presentations take place in catchment areas where people gather, including garages, marketplaces, hospitals and clinics, bantabas (village meeting places), museums, and ferry terminals. Discussions, questions, and answers usually follow the presentations to clear doubts and misconceptions on malaria.
2. To further strengthen the knowledge level of people, NSGA reached all communities with a large-screen community film show reaching over 30,075 people right across the board with malaria prevention and control messages.

In #1 above, PHEs developed their plans after participating in their own self assessments, as did the Drama Troupes. In #2, NSGA staff said that these screenings were a response to requests coming from communities after they had participated in self assessments. However, the size of the population reached through screenings would indicate that this activity is possibly a project-led mass outreach rather than a response to requests from individual communities. In the interests of rigor, the evaluation would prefer to exclude #2 as a legitimate outcome of MCC.

USAID-funded assessment: In 2007, NSGA received a one-year grant of US\$ 111,208 from the USAID-funded AWARE-RH Project to implement and evaluate integration of the MCC approach with PHEs in two regions of The Gambia—Western North Bank Region and Eastern North Bank Region. The project ended at the end of April 2008. AWARE-RH conducted a baseline and final evaluation of the project. At the time of this evaluation, the report was not yet final.

Through the AWARE-RH PHE Project, NSGA and the NMCP trained 40 facilitators at the national level drawn from the two regions. These facilitators included teachers, school principals, community health nurses, officers in charge of hospitals, and public health officers. These facilitators were given responsibility for facilitating self assessments with extension workers in 15 of the largest communities in the two regions. The total combined population of these villages in 2007 was 50,827. In each of these communities, self assessments were conducted by women's groups, drama groups, PHEs, and opinion leaders. Each of these groups prepared action plans, which they implemented over the ensuing year. These action plans include visits to surrounding, smaller communities to share what they had learned about malaria control.

NSGA set up a monitoring and reporting system, which involved written reports by each of the community groups on their activities during the month, and plans for the next month's activities. NSGA supported coordinators in each of the two regions to follow up with the communities on a regular basis. Marie Chorr, who coordinated the project, and Adama Jagne Sonko visited approximately eight communities three months after the first self assessments to monitor activities against action plans, and to provide advice if the community groups were experiencing problems. Thereafter, Marie accompanied her team to visit communities once a month.

At the end of the year, NSGA assisted each community to conduct a second round of self assessments. Most of the plans had been implemented, and most communities registered great improvements on all 14 malaria-related competencies in the self-assessment framework.

A member of this evaluation team visited one of the villages in this assessment project, Illiasa, in the Upper Baddibu district and met with members of the women's group, the drama group, and the PHEs, and conducted a focus group discussion with 11 women and 5 men from the drama and women's groups.

Community members felt that the number of malaria cases in Illiasa had reduced since the community began implementing their malaria control plans. Several said that their children or they themselves used to get sick with malaria

frequently, but in the past year most had not had any malaria. Several said that they had started sleeping under ITNs, and many said that they used to sleep outdoors at night, but now they sleep indoors with the doors and windows closed to avoid mosquito bites. One of the men said that he now takes his children to the health centre immediately when they become sick. Some of these impressions are borne out by malaria figures from the health centre there; the periods from January through April 2007 and January through April 2008 show an appreciable decline in the number of children under age five with uncomplicated malaria cases reporting to the health centre (Table 7).

Table 7. Malaria cases from health centre

	Year	January	February	March	April	Total
Under-5 uncomplicated	2007	213	224	261	242	940
	2008	185	105	106	246	642
Malaria in pregnancy	2007	12	11	11	10	44
	2008	8	11	18	26	63

The figures above also show an increase in the number of pregnant women reporting for treatment of uncomplicated malaria over the same time period. This is puzzling especially because there has also been a decline of 75% in diagnosed cases of malaria in pregnancy between 2003 and 2005, which the NMCP attributes to increased use of ITNs, increased uptake of IPT during pregnancy, and intensive social mobilisation targeting male community leaders and women. This is part of a larger decline: since 1999, The Gambia has registered continuous declines in malaria cases as measured by malaria-positive microscopy, the largest decline occurring between 2000 and 2004.

It is of interest that the communities funded their activities themselves through osusu, or local microsavings schemes among women's groups, and through local village banking schemes. The NSGA provided funding for PHEs, community drama groups, and women's groups to visit other villages.

Community members said that their community was much cleaner than it had been in the past. Some of this may be attributed to action plans that were developed after the self assessments by the drama group and the women's group to clean the village on a regular basis in order to reduce mosquito breeding sites. The action plans also aimed to promote the use of ITNs among pregnant women and children under 5 years old, and to conduct education sessions at the health facility to promote IPT among pregnant women. They also visit other communities with members of the health centre staff to conduct community sensitisation about malaria during outreaches every week, and perform dramas and songs about malaria both in Illiasa and in other neighboring communities.

Members of these groups said that they had benefited from self assessment in some way, and many referred to increased technical mastery of the disease. A few admitted that they now take malaria more seriously than they did in the past. Some of the women said that they now take it upon themselves to educate others about malaria at every opportunity—while working in the rice fields, or when visiting with neighbors. The headmaster of the village nursery school said that

he now teaches his students about malaria and tells them to sleep under nets. He sometimes visits their homes to see if they use bednets. He has noticed that his students are not getting malaria as often as they used to.

A second self assessment was conducted recently by the women's groups and the drama group, and led to three new priority targets: educating the community about the new malaria treatment policy with ACTs; increasing ITN use among children below age five; and reducing mosquito breeding sites through community cleaning exercises.

## Sierra Leone

According to a malaria situation analysis conducted in 2004 by the Sierra Leone MoH, malaria is responsible for 47% of outpatient morbidity among children under five years of age and 37.6% of all hospital admissions; malaria has a case fatality rate in Sierra Leone of 17.6%. According to the National Malaria Strategic Plan 2004, 38.3% of deaths among children under age five and 25.4% of deaths across all ages are caused by malaria.

The Sierra Leone NMCP approaches malaria control through four main strategies:

- IPT with two doses of SP during pregnancy (three doses if woman is HIV positive).
- Free ITN distribution to pregnant women during first antenatal visits; or immediately after childbirth for mothers who deliver at health facilities.
- Free ITN distribution for children below age five during immunisation or when they receive vitamin A.
- Treatment through clinical facilities with artemisinin-based combination therapy (artesunate-amodiaquine)

The MoH has designed an IRS strategy, and plans to begin implementing it in the near future. It is also working on a strategy for home-based management of fever through community-based drug distributors.

According to a baseline malaria survey conducted in June 2005, 25.7% of households had a mosquito net, with only 14.7% of households having an ITN (14.7%). Overall net ownership in rural areas was slightly higher than that in urban areas. About 17% of the children surveyed slept under a net the night before the survey; however, only about 10.3% slept under an ITN.

The percentage of pregnant women who slept under an ITN the night before the survey was 12.4%. About three times more pregnant women in the rural areas slept under a net compared to those in the urban area (16.0% versus 5.2%). The IPT usage rate was also low, with about 19% taking at least two doses.

In 2007, the Centers for Disease Control and Prevention (CDC) conducted a mass net distribution to the entire country, and following the distribution conducted an evaluation that showed ITN coverage had greatly increased. According to the evaluation survey, 56.1% of children under age five and 49.7% of pregnant women reported sleeping under ITNs.



The same survey also showed that access to appropriate treatment is still very low among children under age five. Only 10% of children with fever were treated correctly at a health facility in 2007. MSF piloted home-based management of fever in Bo and Kano Districts, and the MoH is planning on adopting this strategy to improve access to treatment.

During the evaluation visit, it was not possible to tease out whether the changes in malaria indicators (ITN and IPT use) could be attributed to the MCC approach or to other interventions. It is only now that the coaches are having some success in mobilising funds to implement the MCC approach on a wider scale, and this may be the opportunity they need to evaluate the outcomes and effects of this approach.

**MCC implementation in Sierra Leone:** Two individuals from Sierra Leone trained as facilitators in the Mombasa workshop on MCC organised by The Constellation for AIDS Competence July 19 to 22, 2005: Ms Wani Lahai, Public Health Sister and Advocacy and IEC Focal Point with the Sierra Leone NMCP; and Mr Joseph Senesie, Regional Special Projects/Health Coordinator with World Vision Africa. A third person, Mr Ibrahim Kamara, Growing Up Health Advisor with Plan Sierra Leone, was also at the workshop but as part of the facilitation team in his capacity as one of coaches of The Constellation for AIDS Competence.

Most of the efforts made since the 2005 Mombasa workshop have focused on trying to get organisations to adopt the MCC approach. The training done was mostly for organisations. The coaches have only had the opportunity to introduce the approach in a few community settings, and none of them have been evaluated to see what impact the approach had on malaria practices or outcomes. Here is a partial list of what the three Sierra Leone participants accomplished after the Mombasa workshop:

1. Joseph Senesie and Wani Lahai conducted a training in malaria competence for the World Vision national office. Following this briefing, the Area Development Programme (ADP) manager from Bumpeh requested training in MCC for the villages in his ADP.
2. Joseph Senesie and Ibrahim Kamara trained and nominated David Kpevai of World Vision to The Constellation as an MCC coach.
3. Joseph Senesie and David Kpevai trained stakeholders from Babo ADP, and David subsequently trained six communities in Bumpeh ADP and six communities in Serabu in the MCC approach. All conducted self assessments, set targets, and made plans.
4. Ibrahim Kamara oriented the Plan Sierra Leone staff, who realised after self assessments that their main weakness was the lack of funds to implement malaria control programmes. As a result, the organisation submitted a proposal to the European Union for a MCC programme in two districts with a combined population of 850,000 people, and has received approximately US\$ 1.5 million over five years to implement it.
5. Ibrahim also trained an NGO called CADO in MCC, and it has now decided to make malaria a priority for its programmes.

6. Wani Lahai, Ibrahim, and Joseph shared a report of the Mombasa workshop during a workshop for the entire MoH, including the deputy minister of health.
7. Ibrahim has now adapted the MCC approach to child health, and Plan Sierra Leone is using the approach.
8. Wani used the MCC approach in two communities in Western Area. Both communities conducted self assessments, set targets, and made action plans. She worked with the village health committees. In one community, their plan was not implemented. However, in the other community, fishermen in the community banked some of the money they earned for emergency transport and fees for treatment at the health facility as a direct result of the self-assessment exercise.
9. In March 2007, the MoH began a PHE programme in 30 schools with the Nova Scotia Sierra Leone Association. Each school conducted a self assessment, set targets, and made plans. In May 2008, the ministry conducted a knowledge fair for all the schools involved in the initiative to share what they had learned and what they have been doing. This project was so successful that the MoH has included an expansion to other schools and communities in the Global Fund Round 7 application.

World Vision Health Programme and MCC: According to Francis Lansana, health technical coordinator for World Vision, Sierra Leone, up until three or four years ago, World Vision was involved in relief efforts in Sierra Leone. For malaria, this included net distribution and education of communities about the need for nets. Around the time of the MCC workshop in Mombasa in 2005, World Vision changed its approach from relief to development. Under this approach, World Vision no longer directly manages health facilities, but instead supports the MoH in providing health services, including ITNs for pregnant women and children under five, and ensuring that malaria patients are treated correctly.

World Vision organises its programmes by area development programmes (ADPs). An ADP covers one chiefdom, which typically includes between 50 and 100 villages. Currently, World Vision works in 17 ADPs in 3 of Sierra Leone's 13 districts. Each ADP decides its own priorities for World Vision support, but all of them have health as their first or second priority and all work to some extent on malaria. World Vision did not fully use the MCC approach in its communities under its previous five-year strategic health plan. However, in its 2009 fiscal year, World Vision intends to support the MCC and ACC approaches in all ADPs.

What community members have to say about MCC: In Yengema, a village in the Bumpeh ADP that was visited by an evaluation team member, the first MCC self assessment was done in November 2007. In a focus group discussion with seven men and six women from the village health committee, participants said that their main MCC-driven activity was clearing bushes and other mosquito breeding sites. As a result of the self assessment and planning exercise, the community has passed a bylaw that requires every citizen of Yengema to clean the community each month. The village health committee even conducts inspections and fines households that do not comply. Their plan also included distributing ITNs to all children below age five and pregnant women. However, they have not been able to do this since the nets have been out of stock.

The group said that malaria is still a problem in their village though not as much as it was before October 2006, when they built a health facility and the government distributed ITNs. They felt that the situation had improved since then, and had the impression that there were fewer cases of malaria among children at the health facility now than there used to be. Other information from the group was at odds with this impression: for example, the group cited stock-outs of the new malaria drugs and SPs for pregnant women as their biggest challenges. They also said that ITNs have not been available to pregnant women and children under age five from the health facility for a year now.

A one-year-long shortage of medicines and nets also characterised Serabu, a town in the Serabu ADP, where the evaluation team met with seven male and one female members of the ADP committee. World Vision conducted a training in MCC for representatives of six villages in Serabu ADP in February 2008. During the workshop, representatives from Serabu town conducted an MCC self assessment, set targets, and made plans. When asked what their plan of action was, none of them could articulate it. The ADP manager said that they had decided to distribute ITNs and to sensitise the community about malaria and its prevention. Some of the participants said that low literacy was a problem with workshop participants, making it difficult for them to understand what was going on.

## **Kenya**

Malaria contributes at least 25% of all under-five mortality in Kenya. Children under age five in poor rural malaria-endemic areas experience an average of at least two clinical attacks of malaria each year. First-line treatment with SP is failing at an alarming rate, with over 40% of patients not clearing infections by day 28. There is every reason to believe that mortality, as a consequence of failing drugs, is rising rather than declining. Less than 6% of vulnerable groups sleep under LLITNs. As of 2003, those most likely to use an LLIN were the least biologically and economically vulnerable groups (KDHS 2003), though this has been improving over the past five years.

Malaria is one of the top development concerns for Kenya as 70% of its total population (28 million) is at risk of infection. Every year an estimated 34,000 children below age five die of illnesses related to malaria – about 93 of them each day. Malaria accounts for one-third of outpatient clinic visits. About 145,000 children under five are admitted to hospital annually due to malaria. Each year, over 6,000 pregnant women suffer from malaria-associated anaemia, and about 4,000 babies are born with low birthweight resulting from maternal anaemia (National Malaria Strategy 2001– 2010).

About 70% of the Kenyan population is at risk of contracting malaria. Among this population, children under age five and pregnant women are the most affected. The mortality rate among children under age five is about 112 per 1,000 children (KDHS, 1998), and it is estimated that malaria accounts for a high proportion of these deaths. Kenya is currently facing a crisis in its management of malaria cases due to the exceptionally high treatment-failure rates associated with SP. Studies undertaken to assess the resistance of *P. falciparum* to SP indicate an upward trend.

In recent studies, more than 40% of children failed to clear their infection by day 28. Malaria treatment failure has prompted the Government of Kenya (GoK) to adopt antimalarial combination therapy (ACT). Artemether-Lumefantrine has been selected to replace SP as the first-line antimalarial drug.

The use of ITNs is one of the key strategies adopted by the National Malaria Strategy (NMS). The malaria control strategies identified in the NMS include:

- Clinical management through provision of effective and prompt treatment.
- Management of malaria and anaemia in pregnancy.
- Vector control using ITNs and other methods.
- Epidemic preparedness and response.

The NMS also identified two programmes aimed at supporting the implementation of the above strategies. These include information, education, and communication; and monitoring, evaluation and operational research programmes. Kenya has weak malaria early epidemic warning and early epidemic detection systems, which make the management of epidemics ineffective. The systems being used to distribute ITNs have not been effective in scaling up ITN coverage to the level needed to achieve the new Abuja targets.

Kenya is a stable, well-funded country with numerous development partners and donors. Some of the primary donors for malaria-control activities include GFATM, USAID, DFID, UNICEF, and WHO. Kenya will begin receiving PMI funds in 2008. The Pfizer drug company also funds ACT and IPT private-sector initiatives. The UK-based Wellcome Trust Foundation performs a great deal of both clinical and preventative research in malaria control. Africa Medical Research Foundation (AMREF) and Population Services International (PSI) are two well-funded NGOs that implement malaria control programmes, among many.

Kenya submitted successful Round 2 and 4 malaria Global Fund applications. The principal recipient for both grants was the GoK. The most recent scorecard, dated April 2008, shows that Kenya received a B2, indicating that performance has been rated as less than adequate. This suggests that the level of coordination and ability to execute malaria eradication strategies at the national level may not be strong.

MCC implementation in Kenya: Three participants were nominated from Kenya to the MCC workshop in Mombasa. They were Mary Okech of GoK's Social Service/Gender Department; John Omoro of the Department of Malaria Control, Kenya MoH; and Onesmus Mlewa, then of the Aga Khan Health Services, Kenya, Community Health Department.

In 2008, three years after the Mombasa workshop, the MCC approach has not spread in any significant way at the national level, or even at provincial or district levels. As a facilitator (now coach) charged with moving the process along, Onesmus tried to follow up at the national level but did not get responses. Onesmus feels that in Kenya, a national-level endorsement of the MCC approach was missing, and that this is the root cause underlying the failure of the MCC approach in Kenya.

The Mombasa workshop did, however, lead to several community-level initiatives, all of them facilitated by Onesmus. During the workshop itself, the self-assessment process was conducted in four high-prevalence communities in Mazeras in Kenya's Coast province, and reportedly led to an increase in the uptake of nets, which briefly drew the interest of the MoH. Representatives from these communities visited neighboring areas, and the MCC process reportedly spread to three communities in Kwale.

Onesmus continued follow up with these communities after the workshop, supporting the communities in their plans to ensure that all children and pregnant women had access to nets. Communities developed a credit system for nets, and conducted auctions of farm produce, cassava, and so on to support funding for nets access.

Aga Khan Health Care conducted stakeholder meetings with the MoH and other NGOs to share these small successes. Onesmus introduced the MCC approach, and MoH officials appreciated the contributions of the MCC activities, specifically the increase in net use and the spillover in demand for other health services, such as antenatal care.

Some of the discontinuities in follow-up after this are explained by Onesmus' career moves. He moved to Kerife to Plan International, and after a spell there, joined worked with Population Services International (PSI). District unit health teams regard this as a high-performing area.

While in Plan, he says he continued to use the community competence approach, though now mainly with AIDS, as an empowering tool for communities to organise and demand services. He involved communities in Kerife in the MCC process, which led to antimalaria activities in Vitangani. Community health workers motivated communities on net use by assigning roles among themselves for coverage targets. A revolving fund was used as incentive to community workers for net use.

Why did MCC activities not take off nationally in Kenya? Onesmus attributes the low uptake of MCC to the fact that the Kenyan government already had a number of other strategies for malaria control in place, such as the introduction of LLIN through facilities at a reduced price, and initiatives to strengthen approaches at the dispensary level. However, having programmes and strategies in place did not seem to have deterred countries such as The Gambia and Sierra Leone from introducing MCC approaches.

An analysis of participants from those countries suggests a different explanation. Both The Gambia and Sierra Leone nominated high-level officers with decision-making authority to attend the Mombasa workshop. Onesmus confirms that the participants from Kenya and Uganda did not "have decision-making powers" and "could not influence policy." Table 8 reveals the countries that had nominated high-ranking officials of their NMCPs with decision-making authority to be trained at the Mombasa workshop. In both The Gambia and Sierra Leone, which have shown vigorous progress in MCC activities, not only was there senior representation of the NMCP, but also the nominees included one person with high-level facilitation skills working within a malaria project (Joseph Senesie

in Sierra Leone, and Marie Chorr in The Gambia). Buy-in at the NMCP or governmental levels seems to have ensured support for MCC activities; the presence of a skilled facilitator in a malaria project has helped the diffusion of the MCC process. This combination may be useful for future success. Communication and data from Benin and Cameroon are scanty and so it is not possible to make any assertions. However, Benin's only participants were from the NMCP; and Cameroon's other participant was at the director level and possibly would not have been available for workshop facilitation.

**Table 8. Participants at Mombasa workshop**

Country	Participants	Designation
Benin	Dr Petas Akogbeto	Medical Officer (malaria), NMCP
	Mrs Alice Guidigbohoun,	Social Worker, NMCP
Cameroon	Mr Dominique Kondji Kondji	Director, BCH Africa
	Dr Emmanuel Forlack Allo	Regional Coordinator for the East Province, NMCP
DRC	Dr John Gikapa a Gudijiga	SANRU III
The Gambia	Mrs Adama Jagne Sonko	Deputy Programme Manager, NMCP
	Ms Marie Chorr	Regional Coordinator, Peer Health Education Project, Nova Scotia Gambia Association
Kenya	Mrs Mary Okech	Social Service/ Gender Department, Government of Kenya



	Mr Onesmus Mlewa	Aga Khan Health Services, Kenya, Community Health Department
	Mr John Omoro	Kenya Ministry of Health, Department of Malaria Control
Nigeria	Mrs Janet Martins Offiong	Health Officer, Nigerian Red Cross
Sierra Leone	Mr Joseph Senesie	Health Programme Manager, World Vision
	Mr. Wani Lahai	Advocacy/IEC Coordinator, Malaria Control Programme
Tanzania	Mr Clement Chacha	School of Hygiene
Uganda	Mrs Caroline Gumoshabe	Programme Manager, ARISE

Onesmus feels that this may imply a greater role for the RBM Partnership. “If there is endorsement from an authority that can change policy, the MCC process will move forward. The RBM should fully embrace this, not just support by giving funds, but help create ownership, provide funds for a specific purpose.”

Another factor influencing MCC adoption within a country could be related to initiative and influence of the MCC facilitators themselves. For instance, the Red Cross in Togo has adopted the MCC approach nationally in its antimalaria activities. Dr Blaise Sedoh, Constellation coach and also one of the facilitators at the Mombasa workshop, is the coordinator and chairperson of the Togo Red Cross AIDS Programme. This is an interesting instance where the coach wielded enough decision-making authority to push for the widespread adoption of community competence processes within his organisation. Togo was not an official participant of the Mombasa workshop; its inclusion as a MCC country is entirely linked to Dr Blaise Sedoh’s commitment.

## Networking and sharing

Sharing of experiences and practices happened at several levels and between different players in the MCC process. At the formal level, there was Internet-based sharing at the Yahoo! Forum (<http://health.groups.yahoo.com/group/malariacompetence/>) moderated by The Constellation. At the informal level, there was unplanned and opportunistic sharing that was based on the phone, email, and fortuitous meetings at events such as workshops and conferences. Since the sharing of experiences and practices is one of the pillars of community competence as practiced in the MCC project, this evaluation looks at the extent to which such sharing may be said to have occurred. Specifically, was there a diffusion of successful or effective practices through any of the platforms named above? Where did networking and sharing happen, where did it work? These are questions being asked in this section.

### The Yahoo! forum

The initial funding supported The Constellation in moderating a Yahoo! discussion forum until the end of 2006. The funds enabled moderation from August 2005 to around April 2006, but the forum continued to see messages even without formal moderation, though the number of messages dropped sharply and never really regained the 2005-2006 levels (see Table 9).

Table 9. Number of messages to Yahoo! forum

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2008		8	1	1								
2007	6	3	1		4				7	3		
2006	25	13	22	15	2	1	13	14	13		11	9
2005							4	50	31	29	35	37

The content of the messages indicates that the communications were social rather than programmatic. Attempts to initiate serious discussions never really took off. Of the 359 online entries, nearly half were posted by either Constellation staff based in Thailand (105 entries), or by any one of the five Constellation facilitators who were invited to the Mombasa meeting (75). The other half, roughly 180, came from the nine countries described in this report, plus a few additional entries. Most of the correspondents were participants in the 2005 meeting, only six participants posted entries to the group who did not attend that meeting.

The most active countries, in order from most to least, were The Gambia, Benin, and Sierra Leone, two of which also energetically lead in MCC activities. The Constellation's coaches from Sierra Leone (Ibrahim Kamara) and from Guinea Conakry (Idrissa Souare) were also quite active, with 36 and 20 postings respectively.

The set of messages below, taken from a 2006 Facilitators' Report, conveys a sense of the amiable and social nature of the exchanges —

Re: RE : [malariacompetence] Global Fund - Round 6

Hi Dominique, nice to hear from you. Do you still in [sic] Tchad?

À bientôt.

Blaise ...

From: marlou de rouw

To: malariacompetence@yahoogroups.com

Fwd: toronto Skills building session on ACP

Dear Malaria Competence Friends,

For those of you who are attending the Toronto Conference the session below is a must!! Also, please do not hesitate to pass...

Re: RE : [malariacompetence] Global Fund - Round 6

Dear Friends, This is just to give an update about malaria competence in The Gambia and round 6 proposal development. The Gambia NMCP recently received a team...

Re: RE : [malariacompetence] Global Fund - Round 6

Dear Ngoro, Thank you very much for sharing with everyone what is happening in The Gambia. Please keep on with the good work.

My best regards,

Ibrahim Kamara ...

“Re: Global Fund - Round 6”

Dear Marlou,

This is a good information. Putting the proposal to global funds is the best sustainable way to implement competence approach in both malaria and...

Re: Global Fund - Round 6 “);

That sounds good, Clement. You can indeed indicate The Constellation as a partner for the NGO in Tanzania to work towards AIDS/Malaria Competence. And yes,...

Malaria competence workshop in Tanzania

Dear Friends,

The first workshop that introduced malaria competence process was held in Zanzibar, Tanzania on 1-5th Aug. The workshop brought together a big...

Re: Malaria competence workshop in Tanzania

Dear Clement, So good to hear that the workshop worked out as planned! I am sure your and Ibrahims facilitation skills highly contributed to that. We are...

Re: Malaria competence workshop in Tanzania

Great stuff Chacha! It is feedback like this that makes what we are doing so worthwhile. I can almost imagine being there!

Cheers

Geoff Parcell ...

Re: Malaria competence workshop in Tanzania

Dear Clement,

Thank you very much for sharing with us (the malaria competence group) how the Zanzibar Fresh Air Malaria Workshop went on successfully. Please let...

Re: StrateGems Against Malaria in Asia

Dear Ngun,

Thanks for the invitation and i hope that where we cannot all attend you will keep us informed through the web. please send the Gambian team our...

The MCC process was not documented comprehensively or in enough detail for an assessment of the extent and effectiveness of sharing of experiences through networking. The Yahoo! forum seems to have enjoyed superficial and short-term popularity, and does not yield specific examples of sharing that led to a dissemination of practices or processes. There are several self-reported instances of contact and consulting between coaches and facilitators, as well as joint participation at external workshops, any of which may have provided an opportunity for sharing of experiences.

During this evaluation, an attempt was made to discover whether similar activities in neighboring countries could be traced to a diffusion of practices across borders, whether through the Internet or other channels. In both Sierra Leone

and The Gambia, there have been activities in which PHEs in schools planned malaria-related interventions. How did similar interventions start up in these two countries?

In Sierra Leone, the MoH began a PHE programme in 30 schools. Each school conducted a self-assessment, set targets, and made plans. In May 2008, the ministry conducted a knowledge fair for all the schools involved in the initiative to share what they had learned and what they have been doing. This project was so successful that the MoH has included an expansion to other schools and communities in the Global Fund Round 7 application.

In The Gambia, the PHEs of Albreda Upper Basic School and Kerr Cherno Senior Secondary School conduct weekly malaria presentations during antenatal clinics at the health centres to sensitise pregnant women and caregivers of children below age five on the importance of early and timely malaria case-reporting and treatment for malaria during pregnancy, and the importance of early antenatal bookings for IPT doses, etc.

The similarity in the programmes emerged during an interview with Marlou de Rouw, Constellation official, who had heard about The Gambia's intervention in conversation with Joseph Senesie of Sierra Leone. "I encouraged him to share this practice—of using community resources (viz. PHEs) and weaving malaria interventions (viz. presentations) on to nonmalaria programmes (viz. antenatal clinics)—on the Yahoo! forum."

Marlou could not corroborate whether the Sierra Leone intervention with PHEs had inspired this activity in The Gambia. However, during evaluation it emerged that the Sierra Leone activity is conducted by the Nova Scotia Sierra Leone Association, which was started around 2003 by the Nova Scotia Gambia Association. The school PHE is a longstanding intervention of NSGA in The Gambia, and it seems that it has now been extended to Sierra Leone.

Thus, this example points not so much to diffusion of practices between organisations and countries through networking but to the scaling up of practices within the same organisation. In summary, there is little evidence to indicate that networking has been a prominent or greatly effective activity within the MCC process. It has been difficult to find concrete instances of shared experiences leading to the diffusion of practices, either through web-based forums or through face-to-face or other interactions.

## Conclusions

As mentioned earlier, the evidence base for this evaluation is not rigorous or exhaustive. The conclusions below are made within the limitations of scanty or uneven data. The rollout of the MCC process across the nine countries being considered in this evaluation seems to have been under-managed and underfunded. The principal contractor, The Constellation, repeatedly referred to their financial constraints, and stressed that they were unable to do all that would have been needed for a successful rollout of a community competence process. There are also clear reports of successes, and these possibly reflect the individual

enterprise, commitment, and initiative of coaches and facilitators, as well as some NMCPs.

Some overall conclusions about what worked and what could work are nonetheless possible about the MCC process, and they are presented below as answers to the main questions driving this evaluation effort:

### **Does the MCC approach contribute to the impact, efficiency, and effectiveness of ongoing malaria programmes?**

The available evidence from both performing and nonperforming countries indicates that the MCC process is a reliable and effective way of engaging community attention and involvement in initiatives that tackle malaria. Since MCC diffuses through facilitators already working in malaria-control projects, the communities they logically choose for building MCC tend to be in their project-related areas. Thus, any gains in malaria control arising from community-led initiatives automatically add to the projects' own effectiveness. For example, the NSGA used the MCC process among their own school PHEs, who conducted self assessments in 15 communities. As a result, these activities strengthened the NSGA's own results.

The only systematic evaluation of the impact of MCC was the one-year grant from the USAID-funded AWARE-RH project. Under the grant the Nova Scotia Gambia Association implemented and evaluated the integration of the MCC approach with PHEs in the Western North Bank and Eastern North Bank regions of The Gambia. The project ended in April 2008, and is estimated to have had an outreach of over 50,000 community members. The evaluation report was not yet released at the time of this writing, but 2007-2008 malaria figures from the health centre at Illiasa, Upper Baddibu District, show a significant decline in cases among children below age five, and an inexplicable increase in cases of malaria during pregnancy. Without contextual data on services and net provision, it is not possible to assert any clear relationship between MCC activities and impact on malaria prevalence.

At a broader level, certain conclusions stand out:

1. The MCC approach seems to have taken deeper root in West Africa than in East Africa. It is striking that two of the highest-performing countries that have demonstrated a profusion of local, regional, and national activities—Sierra Leone and The Gambia—are also among the ones that attended the Health for Peace meeting in Banjul, June 2005, heard a presentation on the community competence process, and witnessed a self-assessment process in a community of Banjul. In the Banjul Declaration Action Plan, The Gambia specifically listed self assessments at the divisional and community levels as a national commitment. These two were among the first countries that evinced interest in the MCC process, and endorsed the idea of introducing community competence in their countries. It is significant that countries whose buy-in to the MCC process was secured at the highest levels through a consultative and experiential process have shown the most sustained outcomes over a multiple-year span. A deeper understanding of this might inform future advocacy around the introduction of MCC.



2. The MCC approach showed extensive and sustained results in countries whose nominees included one high-ranking representative of the national malaria programme and one person with a high level of facilitation skills. This combination seems to be a prerequisite if the rollout of MCC is to receive support at a national level. Where this combination was missing—as in Kenya and Uganda, among the countries evaluated—MCC activities that were initiated at the community level did not result in any significant scale-up to regional or national levels. Creating a base of understanding and support for MCC at the highest levels of national malaria programmes and institutions, and well-trained facilitation resources at the community level may be the necessary chemistry for a successful MCC rollout.

3. The Constellation coaches played a seminal role in helping start and sustain MCC activities. It is difficult to understate the role played by The Constellation's coaches, who facilitated the Mombasa workshop. They were especially important in conveying the spirit and philosophy of community empowerment as well as for building the skill base for facilitating the MCC processes and tools. Beyond the first workshop, they seem to have played an important catalytic and organising role in ensuring that the MCC processes stayed active. This observation in no way diminishes the contributions of facilitators trained by the coaches, who have helped seed the community competence way of thinking across regions and communities. In both the West African countries evaluated, The Constellation's coaches, Joseph Senesie and Marie Chorr, were prominent players (they attended Mombasa as facilitators but were inducted as coaches later). In nearby Togo, Constellation coach Dr Blaise Sedoh, coordinator and chairperson of the Togo Red Cross AIDS Programme, helped ensure the organisation-wide adoption of the MCC approach by the Red Cross in Togo. Even in Kenya, a country classified in this evaluation as a nonperformer in MCC, the Constellation coach Onesmus Mlewa was vigorous in introducing community competence approaches under his employing organisation's projects, although MCC remained local because of lack of government-level support. Indeed, even without evidence to the contrary, it is very unlikely that MCC processes would have taken root without the continuous engagement of the coaches, and the performance of The Gambia, Sierra Leone, and to an extent Kenya is ample demonstration.

This observation adds weight to The Constellation's contention that the community competence process requires “accompaniment” by the coaches beyond the initial workshop right down to the grassroots community level.

### **What is the contribution of networking and cross-community knowledge sharing between MCC participants in improving the quality and impact of malaria programmes—compared to participating countries that do not have MCC activities in place?**

It is difficult to conclude that networking was a key factor in the dissemination of lessons and best practices with the MCC project. Indeed, there is little evidence, either qualitative or quantitative, pointing to cross-border or cross-community migration of practices and learnings. Based on the analyses done by the evaluation

team, it is not possible to make a substantive assertion that the Internet forum played anything more than a social supportive role.

The Constellation's contract called for them to moderate a Yahoo!-based discussion forum. Beyond the Internet, and email and telephone conversations, they had little systematic or formal management supervision over when, where, and how coaches and facilitators met and interacted. It is not clear why Internet-based sharing received so much emphasis in a continent where only 5% of the population has connectivity, where broadband access is limited to largely urban settings, and where power cuts and ease of access pose significant issues. Geoff Parcell, a knowledge management professional from British Petroleum, one of the partners in the development of ACC, acknowledged that culture and Internet connectivity were issues.

"When you talk to individuals, they would tell you of meeting someone face to face, maybe at workshops, cross-country," he said. "They may have used direct email, or phone calls, or Skype. In British Petroleum, I am finding that the electronic discussion only worked if a person had had face-to-face contact. My experience is that networks tend to be far more social."

Other conclusions regarding networking and cross-community knowledge-sharing are:

1. The practice of knowledge capture and the structure of KAs may not have received sufficient attention. In the absence of specific data to help understand how KAs were used, by whom, and whether the intended beneficiaries found it effective and easy to use, it is worth observing that KAs in their current form are extremely pithy. The generic principles or advice being proposed as a good practice are usually a sentence long. The experience from which the principle is being drawn is a paragraph long. For greater detail, further discussions are recommended with the author of the experience. The language of the KAs is technical and programmatic, and presupposes some familiarity with development language and terms.

Some obvious questions are: Is the creation and sharing of KAs intended to be a community-level skill? Who decides what qualifies to be converted into a KA? What is the process for distilling a principle from an experience? What is the best format and language for sharing it, and should it be variable from community to community? Where should the repository be situated? Finally, how should KAs be disseminated?

2. Face-to-face networking among coaches and facilitators may be more productive as a method of sharing. There are numerous casual mentions of meetings and consultations between coaches and facilitators, some fortuitous and others deliberate. The only such officially convened meeting with the specific purpose of reviewing progress and sharing lessons and experiences happened in Yaounde about six months after the Mombasa workshop. Judging from the success of that meeting, which included a knowledge fair, structured face-to-face interactions are possibly a more effective mechanism for experience sharing and KA creation than an Internet-based forum, although such a forum provides a geography-independent location for storing lessons learned and success stories.

## **What observations suggest that the MCC model is having an effect on the community's sense of participation in and ownership of its malaria problem and solutions?**

“Sense of ownership” is a much used (and abused) term in the language of development. One of the few attempts to define its meaning and propose it as an indicator of progress is the framework of Communication for Social Change, developed by a Rockefeller Foundation-funded team in 2002. This defines sense of ownership as the community's feeling or belief that the problem, issue (or programme) belongs to them and that they have a commitment to the programme. How intensively and extensively the people are involved in defining the issue or programme, the planning process, and the implementation affects the sense of ownership.

“Ownership develops when partners play a key role in formulating and implementing a project and understand the benefits of participation. The recognition by each partner that he will be better able to achieve his own goals by collaborating and helping his partners reach their respective goals is the best way to ensure partners are committed for the long haul.”

—Kraemer, J.

The framework continues with: “Even though an external agent may help determine the needs or programme goals, and guide the implementation process, the community should be heavily involved so that a sense of ownership can develop. The gain of creating a sense of ownership is that it reinforces what people learn and encourages them to integrate the shared learning into related situations. This in turn, feeds back into strengthening other social change outcomes such as ‘sense of collective efficacy.’”

The framework of Communication for Social Change proposes the following dimensions for a measurement of this outcome:

1. Importance of the issue or programme to participants.
2. Sense of responsibility for the programme.
3. Contribution to the programme.
4. Benefit from the programme.
5. Participants' sense of ownership of either credit or blame in the programme's outcome.
6. Personal identification with the programme.

A rigorous answer to whether or not communities participating in the MCC process developed a sense of ownership would only be possible after a systematic evaluation based on agreed upon indicators such as the ones above. In the absence of those, but based on the interviews and desk research, we may conclude that:

1. Communities who participated in a self-assessment process self-identified issues and priorities of importance to them. Since the self-assessment process encourages reflection along a 5-point scale and 14 measures of competence, the community actively assesses its position and sets its own priorities. This is

inherent to the structure of the self-assessment tool, and is possibly a strong contributor to a sense of ownership.

2. Since communities have raised resources from local sources on their own initiative, it is clear that there is a strong sense of responsibility for the activities planned. There are documented instances in The Gambia where community groups tapped into local unused or available resources to pay for buying and distributing ITNs.

3. If programme is interpreted as the activity resulting from the self-assessment process, then the community sense of ownership of it would be total. This would be so because the activity emerges from a community assessment of their strengths, needs, priorities, and resources. An external facilitator plays a catalytic role in the process but the initiative and control of the outcomes rest entirely with the community.

4. The main beneficiaries of the activity are the community. This is axiomatic, since the activity was designed by the community to solve issues faced by them. If the activity succeeds, the community is the prime beneficiary, although any antimalaria project in the same setting would also benefit.

Without the benefit of a formal evaluation, it is possible to conclude that the MCC process is very likely to foster a strong sense of community ownership.

### **What MCC resources, processes, and programming seem to be working well? What shortcomings in resources, processes, or programming could be addressed and thus lead to better outcomes?**

*Self assessment, SALT visits:* The self-assessment tool has consistently been described as useful, notwithstanding comments that it could be simplified and made more user-friendly. The fact that the self-assessment tool was used quite widely across all nine countries also suggests that the preliminary SALT visits were successful in awakening community interest in the self-assessment process.

*Coach network:* The Constellation's network of coaches comes across consistently as skilled, pro-active, and creative, with a high degree of self-motivation and commitment to helping build community strengths and competencies. This network has remained vibrant despite numerous constraints, and constitutes a unique asset in any community competence process, notwithstanding comments that they could emerge even stronger from a clearer articulation of selection norms and greater attention to face-to-face meetings.

*Community participation, engagement, and ownership:* Wherever buy-in was secured at authoritative levels of NMCPs, Constellation-trained facilitators were able to forge ahead with MCC, scaling up community participation and engagement, usually within the settings of their existing projects. This stands out as a specific, and possibly repeatable, programmatic feature.

*Capacity building:* The Mombasa workshop was outstandingly successful in creating the impetus, enthusiasm, and skills for a widespread diffusion of MCC in the participating countries. MCC did not take off as it should have due to a

complex of other factors including limited funding and management, but The Constellation's seminal capacity-building process stands out as sturdy and effective.

## Shortcomings

*Management plan:* The absence of a long-term plan with management goals and a budget is possibly the most visible lacuna in the MCC project being evaluated. Outcomes were defined at the programmatic rather than the community level, including workshops and distance facilitation. Deliverables were limited to specific events such as workshops, and there is a conspicuous absence of explicit management responsibility for the final outcome of the MCC activities. Finances were arranged and made available in an ad hoc manner, which led to fitful and limited implementation that effectively lasted only through 2006.

*Budget:* The MCC project worked within unrealistic financial constraints, which made many essential steps of a successful rollout impossible. Since the RBM Partnership is not a funding body, their efforts to secure funding for MCC remained a tangible impediment, and affected every aspect of the project. It seems extremely likely that MCC could have shown much more consistent outcomes across the countries with a better conceived long-term plan and goals, a clear allocation of funds and responsibilities, and better supervision.

*Sustained engagement of coaches:* The formal involvement of coaches was primarily at the Mombasa workshop. Beyond this, their involvement was voluntary and inconsistent across the countries, resulting in uneven outcomes in MCC. Mentoring of newly trained facilitators and newly participating communities by coaches was necessary but not possible because of financial constraints. This is likely to have had a deep impact on the quality of activities and engagement at the community level.

*Networking:* Limited finances were focused on moderating a web-based Yahoo! Group platform whose success has been limited to social interactions rather than deep programmatic sharing of lessons and practices. Face-to-face networking, supplemented by email and telephone, which happened on an ad hoc and informal basis, appears to have played a more significant role in sharing and diffusion of learnings.

*Evaluation plan and framework:* There was neither a clear evaluation plan nor agreed-upon external indicators of success. In the absence of information, it is also unclear to what extent participant communities conducted Self Measurement of Change, and whether their indicators were consistent and comparable across borders. Drawing clear conclusions about the effectiveness of MCC would be easier with greater attention to this aspect.

## Recommendations

The recommendations below fall into two categories. There are specific programmatic recommendations arising from the evaluation process. These reflect findings, analyses, and comments noted during interviews. The second category of recommendations responds to the terms of community competence's

definition, its inherent potential, and opportunities to strengthen its perception and influence. These are best viewed as points for further discussion.

## **Programmatic**

*Expanding the global network of coaches:* Since the availability of high-caliber community competence coaches seems to be the tipping point that determines how well MCC succeeds, it is worthwhile focusing on ensuring that there are enough coaches to sustain a greater interest in MCC. If the MCC approach expands, then its main vulnerability might lie in the calibre of the coaches who help launch the process in different settings.

*Articulating the coach selection process:* The Constellation should help capture and articulate the skills and judgement that go into identifying, recruiting, and training coaches who can propagate the spirit of community empowerment and the skills of community competence processes. There is need for a user-friendly guide that could aid other organisations in developing their own coaches and launching their own community competence processes. If the community competence process gains wider acceptance, creating interest in replicating its methods, then an essential first step might be standardising the process for developing coaches.

*Developing a framework of monitoring and evaluation indicators for MCC:* It has been a long-standing challenge to find measurement variables that encompass community competence and capacity change which are not simply aggregates of measures of individuals or service providers. Another challenging aspect has been the development of leaders able to fill the role of animator (stimulate community members to think critically, identify problems, and design solutions) and facilitators (providing a process by which the group can discuss its own content as productively as possible). In the case of MCC, these roles are fulfilled by coaches and facilitators, but there is a need for criteria for evaluating their own skills and effectiveness.

*Simplifying the self assessment framework:* The self-assessment framework has been repeatedly described as being overly technical and difficult for low-literacy communities to understand. Making self assessment more visual may make it less challenging. Similarly, using analogies and locally-developed terminology could customise it so that local communities are able to comprehend it. Including a negotiation of local language for terms in the self-assessment framework may be a useful step.

*Reviewing the format and contents of KAs to assess their community-friendliness:* KAs are currently cryptic, technical, and programmatic. For their commonplace use as a community tool, more time should be spent in examining their structure, style, contents, development process, target audience, and ownership. In a new avatar, the KA could become an important addition to the process of documentation and propagation of success and lessons learned.

*Formalizing a structure for increasing face-to-face experience-sharing interactions across communities and countries:* Budgeting and planning for structured experience and knowledge-sharing events could dramatically alter the speed of



diffusion of MCC across communities. Especially if accompanied by an overhaul of KAs to make them more community-friendly and “teachable,” this could become a powerful dimension of community competence processes. The use of Internet-based forums has not enough evidence to support it and its absence may not affect the MCC process in any way.

*Ensuring that high-ranking NMCP officials and high-calibre facilitators are nominated from each participating country in future rollouts of MCC:* Securing high-level buy-in from NMCP officials in the participating countries is likely to be a crucial first step in successfully introducing community competence. To see this advocacy as the first step rather than the training workshop is a paradigm shift that could assure a greater chance of a successful rollout.

*Seeking funds to validate results in Sierra Leone:* It would be of great value to assess the results of MCC in Sierra Leone in a systematic and methodical manner as was done in The Gambia with the USAID-funded AWARE-RH project. Since Sierra Leone and The Gambia rank among the best-performing MCC countries (in addition to Benin and Togo), any evaluation funding available could be usefully spent in showing and showcasing systematic results through a limited, funded activity.

## **For further discussion**

*Negotiating turnkey contracts for building community competence:* Managing agencies such as The Constellation stand to lose both in terms of outcomes and also institutional morale when they undertake community competence commitments in a piecemeal or ad hoc manner. It is clear that a successful rollout of MCC requires a certain finite number of irreducible steps, a certain time frame, a certain commitment of management time and resources, and a certain budget. Accepting to deliver community competence with less than this would possibly be a guarantee of poor results—damaging to the managing agency but also to an appreciation of the inherent strengths of the community competence approach and processes.

*Reframing the narrative around community competence to reflect negotiated collaboration between communities and external stakeholders:* It is clear that MCC has both a community dimension and also a benign external input. Many of its impelling characteristics are external to the community: the technical framework itself is externally developed; it is funded externally; its goals are related to disease reduction but also to the strengthening of ongoing projects through increased community ownership and engagement. It is a paradox of the MCC process that the prime moving engine of change within the community is external to the community—namely the input of the facilitating agency, such as The Constellation.

*Strong elements of collaboration and agenda negotiation are also inherent to the SALT and self-assessment processes:* For instance, the choice of disease is already built into the framework, and is therefore an a priori predetermination ahead of community input. In principle, the self-assessment process is open-ended enough for the disease assumption to be rejected by the community should they feel that some other condition, say unemployment or income generation, was a higher

priority. In practice, though, there is no instance of such a rejection, which must be partly because malaria is a genuine issue within communities, and also because the facilitators bring a contagious enthusiasm to malaria control. (Indeed, one of the observations of the process by a facilitator was that “malaria community competence is contagious.”) In any case, what is clear is that the facilitator’s role is probably less neutral than it is represented to be. He or she has a strong personal vested interest in securing community engagement in malaria control.

The process of “accompanying” or mentoring of facilitators by coaches, described by The Constellation as essential to a successful MCC process, is yet another example of important but still external hand-holding. Mentoring calls for ongoing, if limited term, delivery of support and expertise to facilitators to counter dilution of content and to ensure high quality and results.

Yet one casualty of language that portrays the community’s potential to address its own problems, which it undoubtedly possesses, is an understatement of the role played by external bodies in creating the motivation and skills to energise the process at the community level. This does not do justice to the fact that MCC is the mutually collaborative outcome of a marriage between the agendas of an outside facilitation team and the community. It can be argued that community competence is the result of a benign and respectful collaboration between a donor, a managing agency such as The Constellation, the coaches and facilitators trained by the managing agency, and the community.

Again, community competence processes and tools were developed by The Constellation, and constitute intellectual property. Their use within community competence projects introduces an influential input that is completely external to all the communities who use it. Some of these processes (such as the SALT visit) might have been termed intrusive in other contexts; within MCC, they are characterised by the utmost respect and sensitivity towards the community.

Reviewing and perhaps reframing the narrative around MCC would pave the way for a more realistic representation of the process, and also set the stage for a more comprehensive evaluation framework. Current indicators, such as they are, focus on the community’s own progress, activities, and performance. Missing is a corresponding set of indicators that evaluates the effectiveness of the managing agency, coaches, or any other agent “external” to the community. Yet their role is visible and crucial.

Fully acknowledging the role of noncommunity players in the MCC process will also allow for a more realistic budgeting of community competence, one that includes the need for long-term supervision, allocated managers, travel for on-the-spot and face-to-face technical support, and planned experience-sharing conventions.

Towards health competence? Constellation coach Ibrahim Kamara in Sierra Leone is among the very few of The Constellation’s network who is adapting the community competence approach to new tasks. His adapted tools address community child health competence and community health competence. The latter is the first community competence tool that has gone beyond a disease-specific approach and instead looks at health in its totality. In so doing, it points

towards a large question that might point towards the future of community competence processes: Do communities define health in the same way that a development agency does? The prevailing public health paradigm defines health as an absence of illness. The dominant approach is based on confronting diseases one at a time. It is arguable that the community competence process as it stands reflects this paradigm. The disease-centric approach is built into the self-assessment process.

Ibrahim Kamara's work in developing a community health competence tool may be on the cusp of a new frontier, in which communities self assess their strengths and needs in health in its entirety rather than within single-disease or single-condition contexts, and use their resources and skills to plan holistic actions that raise community health as a whole to new levels. More details of Ibrahim's process or its results are not available at the time of this writing, but his effort raises the intriguing thought that the community competence process could be transformed and elevated from the inside out by an effort that gives the communities charge of their entire well-being. And perhaps that is where the future lies.

