malaria consortium

disease control, better health

Cameroon: Breaking Barriers

Community Health Participatory Action (CoHPA) for prevention and control of malaria in conflict affected communities — a community dialogue approach

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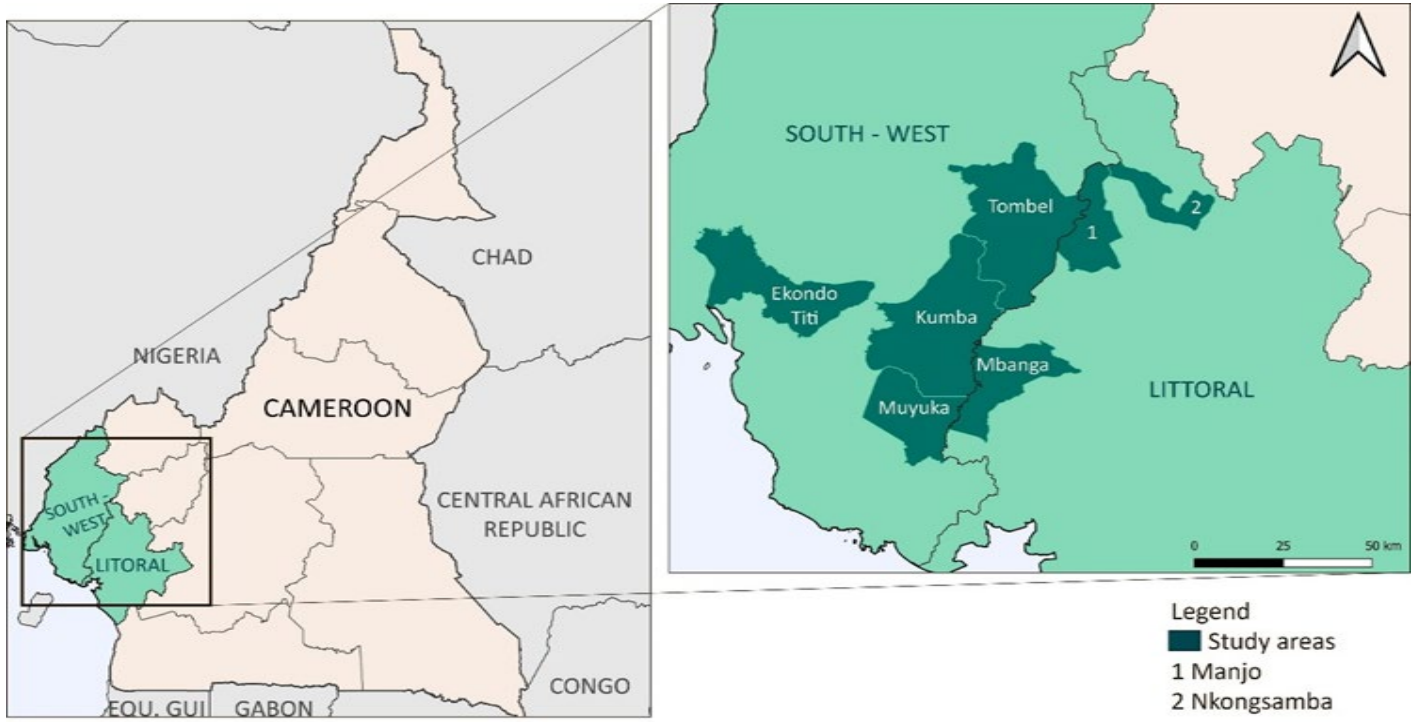
Overview of presentation

Breaking Barriers is a social and behaviour change (SBC) implementation research project identifying three innovative community-based interventions for conflict-affected communities in Cameroon. This presentation covers:

- Context
- Research process
- Implementation
- Qualitative findings
- Perspectives from the field
- Lessons learnt
- Conclusion.

Introduction and situation analysis

- Cameroon has the 11th highest malaria burden globally; 40 percent of deaths are from malaria.
- Conflict in the Southwest and Littoral regions has resulted in:
  - 200,000 internally displaced persons (IDPs) moving between communities and homes
  - shooting, kidnapping, arrests, burning of houses and villages
  - destruction of 30 percent of health services, with two hospitals destroyed
  - IDPs' and returnees' loss of assets and access to health information and services.



Formative research — Co-designed project

Quantitative and qualitative research in 80 communities characterised by

- High malaria burden
- Conflict-affected communities.

Findings

- Low malaria awareness
- Community health worker (CHW) - treatment and drug availability,
- Lack of trust in CHW services
- Low affordability.

Co-design

1. Formative research preference question

- Community dialogue
- Scorecard
- Village health committees.

2. Co-creation workshop

- Community Dialogue Approach developed
- Community Health Participatory Action (CoHPA).

Intervention

CoHPA

Six topics delivered through trained volunteers using flipcharts and training manual supported by field supervisors (REO) and CHWs, evaluated by community score cards (CSCs).

Supportive supervision

Ministry of Health supervisors trained and supported with guidance tool, job aid and monitored by SBC consultant.

Cash assistance

Community health workers (CHWs) gave out vouchers for simple malaria management, transport and hospital care for severe malaria.

Four-month review

Flipchart

- Removed misinterpreted pictures
- Increased content for pregnant women and children under five.

Manual

- Improved signposting and less text
- Increased pictures.

Volunteers

- Refresher training provided.

CoHPA in detail

Community Dialogue Approach

- One field supervisor per district
- Two community volunteers per community
- In total: Five supervisors, 80 communities, 160 volunteers
- Community volunteers trained and provided with a training manual and malaria flipchart; receive regular supervision on the six malaria topics.

Sessions

1. How does malaria affect our community and our life?
2. How do you know that you have malaria?
3. Effective treatment for malaria
4. Malaria during pregnancy
5. Malaria in children
6. Mosquito net care and repair.

CoHPA session content

- The planning meeting was collaborative, conducted with community health workers (CHWs), CHW supervisor, field supervisor, community leader and local counsellors.
- The topic, venue and location were agreed, and mobilisation was agreed.
- The meeting was delivered through participatory activities and discussion.
- An action plan was agreed.
- Feedback was provided using community scorecards.
- A community action plan was completed.

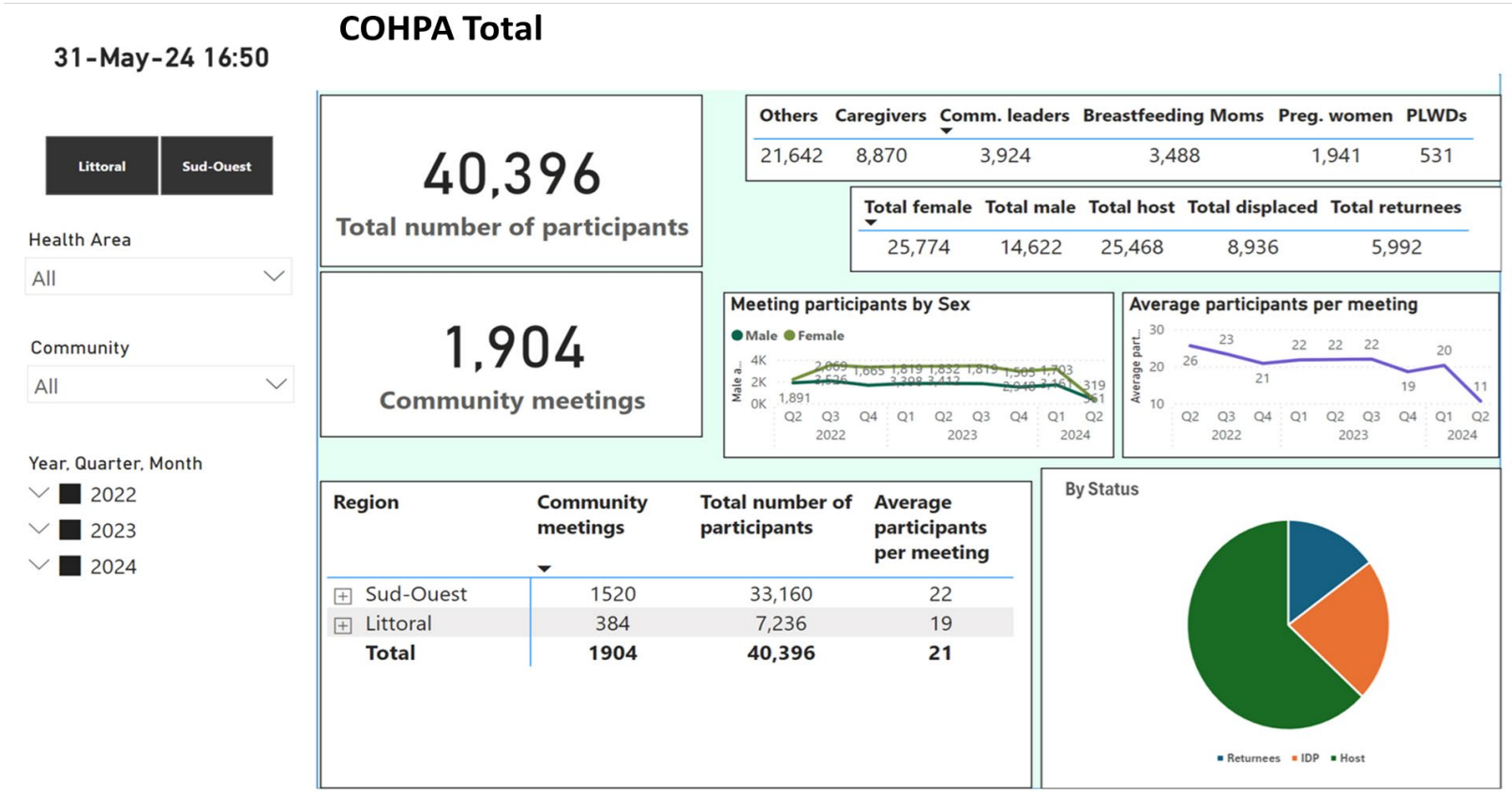
Indicators

Goal: To develop, implement and evaluate scalable, replicable and innovative approaches to improve access to effective malaria case management through community-based services.

- % IDPs who know how to prevent malaria
- % IDPs aware of appropriate health-seeking behaviour for suspected malaria
- Change in the prevalence of malaria from baseline to endline
- Meeting attendance by number of participants; meetings/participant/ disaggregation by age, sex, disability, host, returnee, displaced
- Number of action plans started and completed.

Results

Community dialogue attendance



A total of 23 meetings per community, with four rounds of six topics.

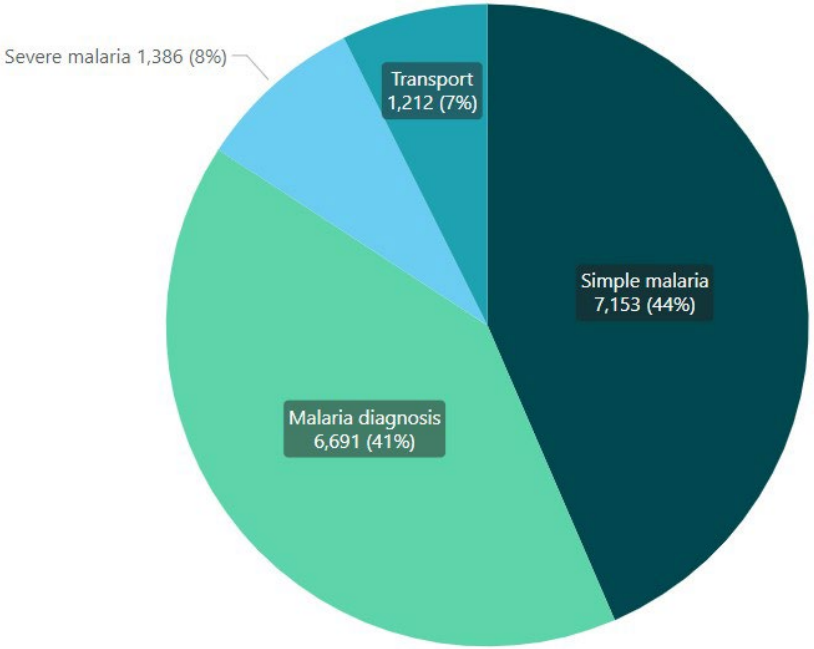
Average attendance 21, representing all community groups:

- 22% IDPs; 63% host; 15% returnee
- Male: 36%; female: 64%
- People living with disabilities: 1%
- Pregnant: 5%
- Breastfeeding: 9%
- Caregivers of children under five: 22%.

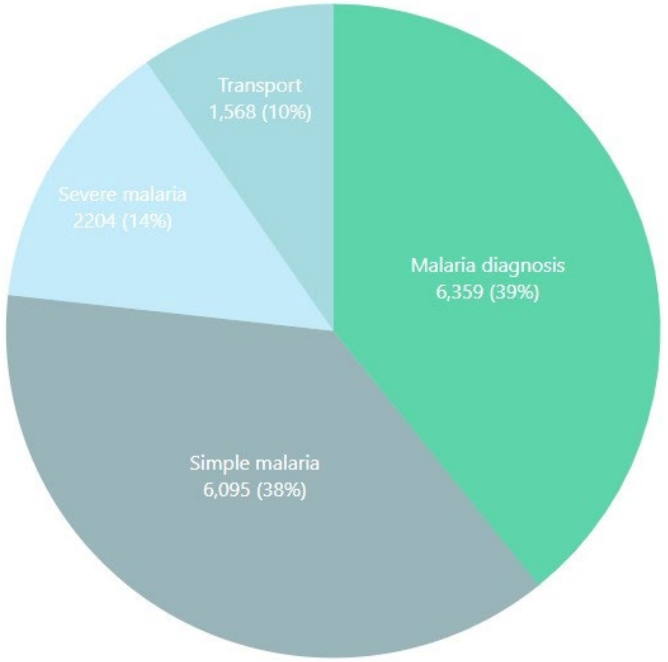
Voucher use

	Simple malaria	Diagnosis	Severe malaria	Transport
Total	16,884	16,292	4,054	3,151

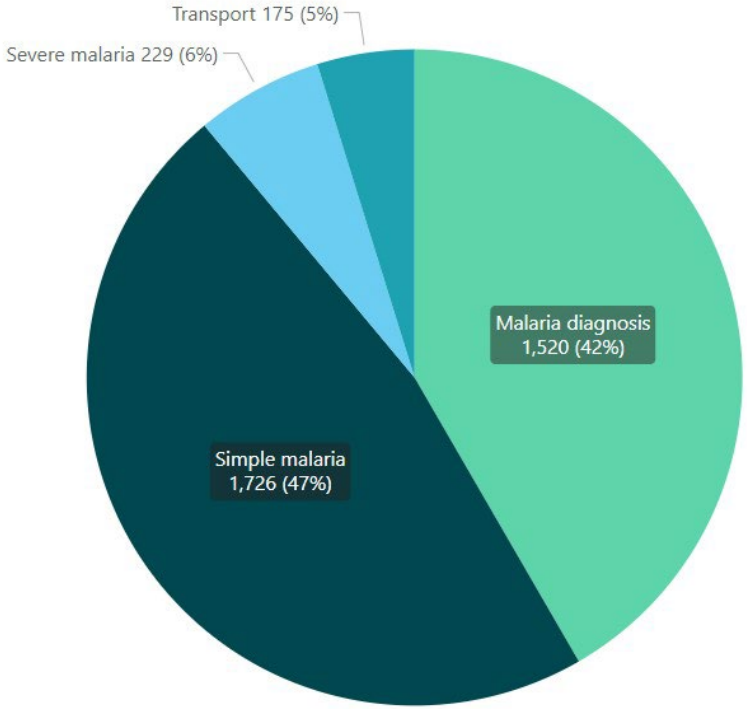
Host



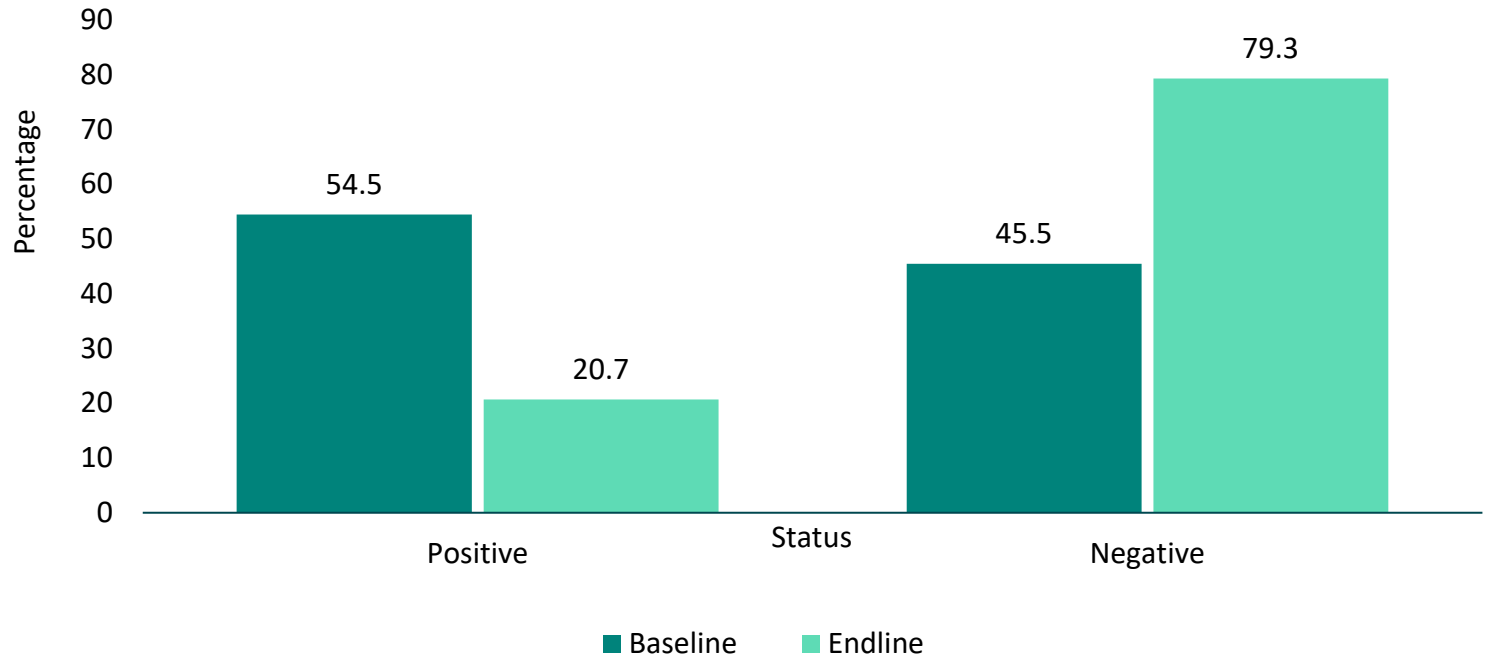
Displaced



Returnee

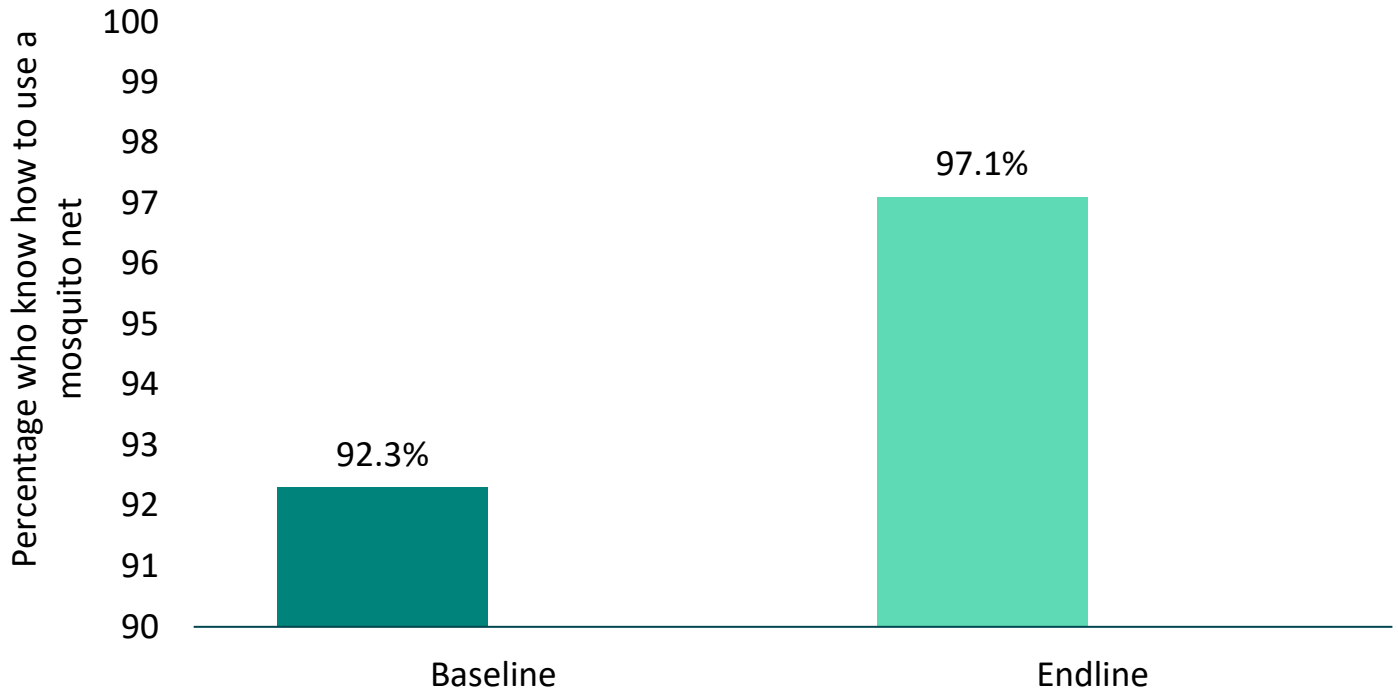


Prevalence of malaria among children under five years



Baseline: 841 (54.5%) children <5 years malaria positive; 702 (45.5%) negative.
Endline: 426 (20.7%) children <5 years malaria positive; 1,631 (79.3%) negative.

Respondents' knowledge of mosquito net use

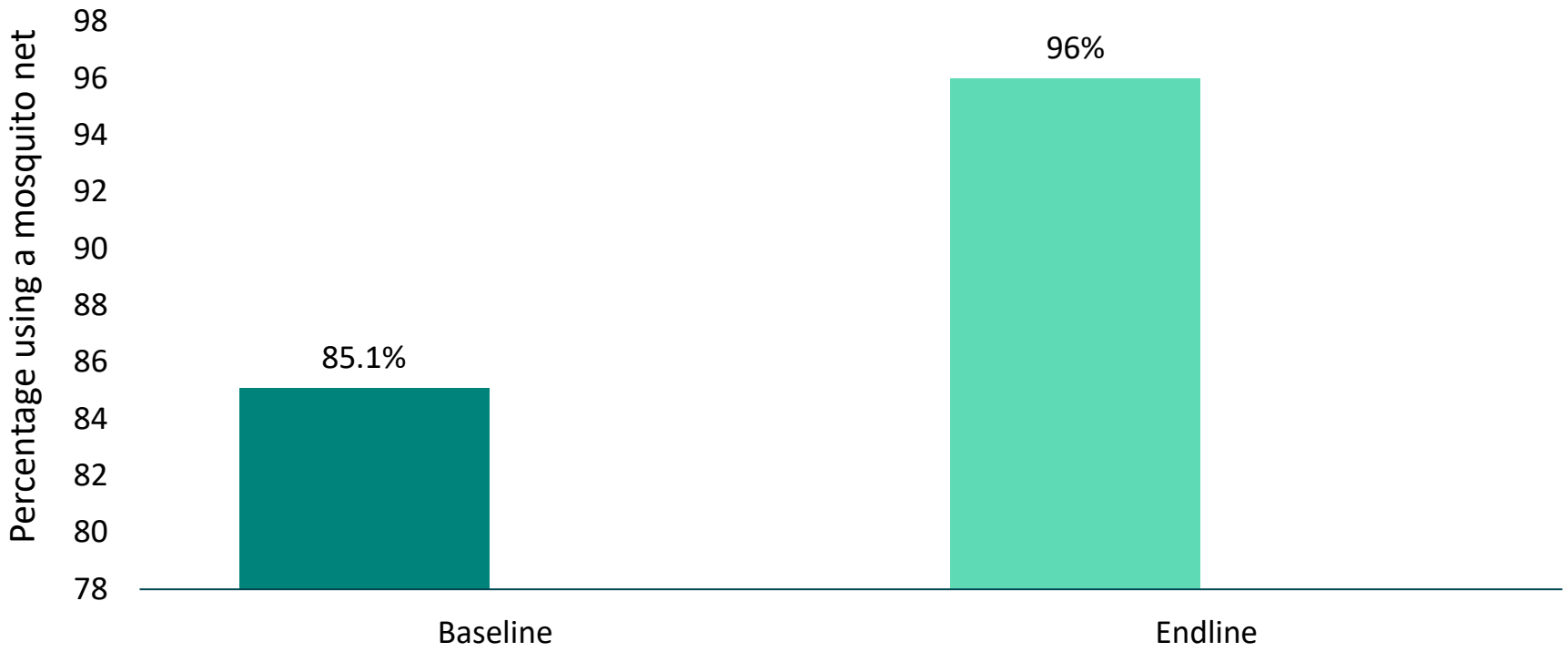


Baseline: 2,197 (92.3%) knew how to use a mosquito net

Endline: 2,435 respondents (97.1%)

Significant improvement of 4.8% ($p<0.05$)

Respondents' practice of mosquito net use

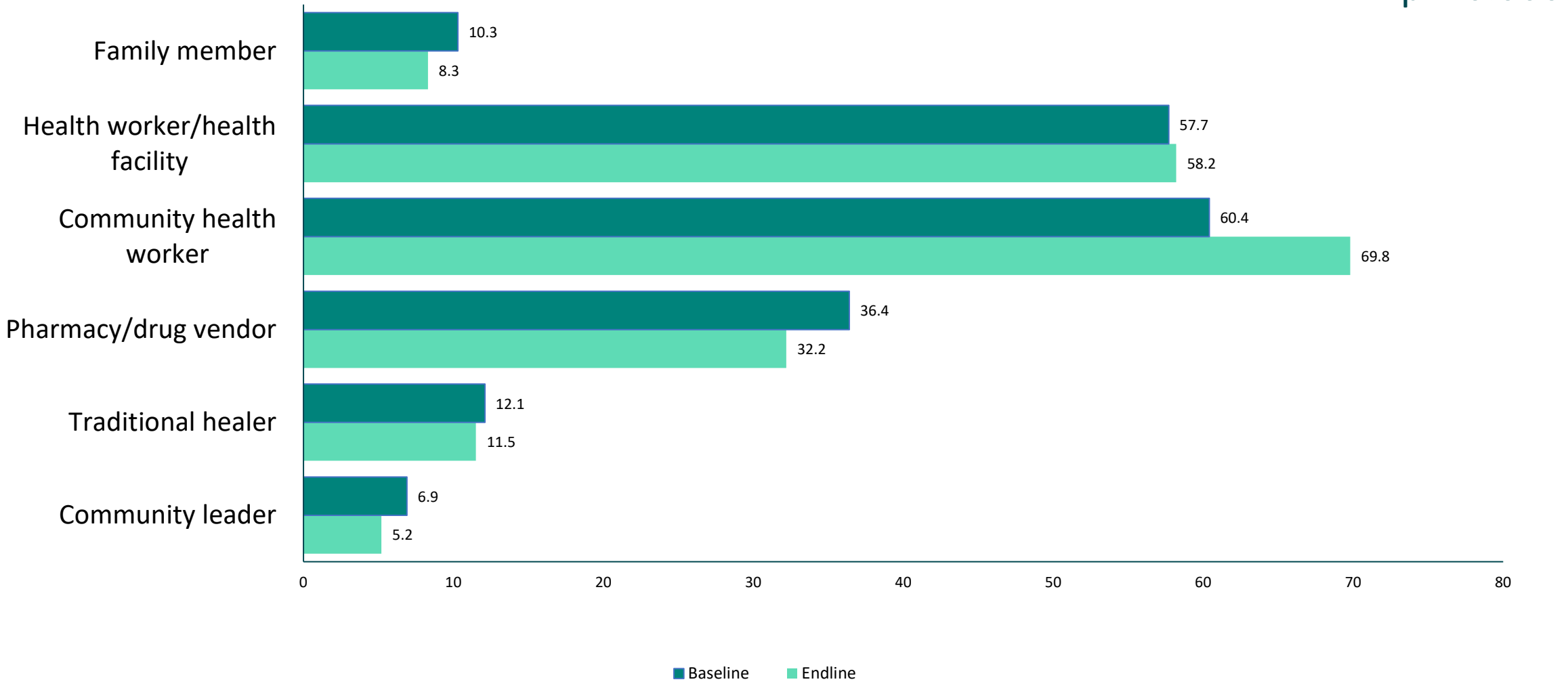


Baseline: 2,021 (85.1%) reported sleeping under mosquito net

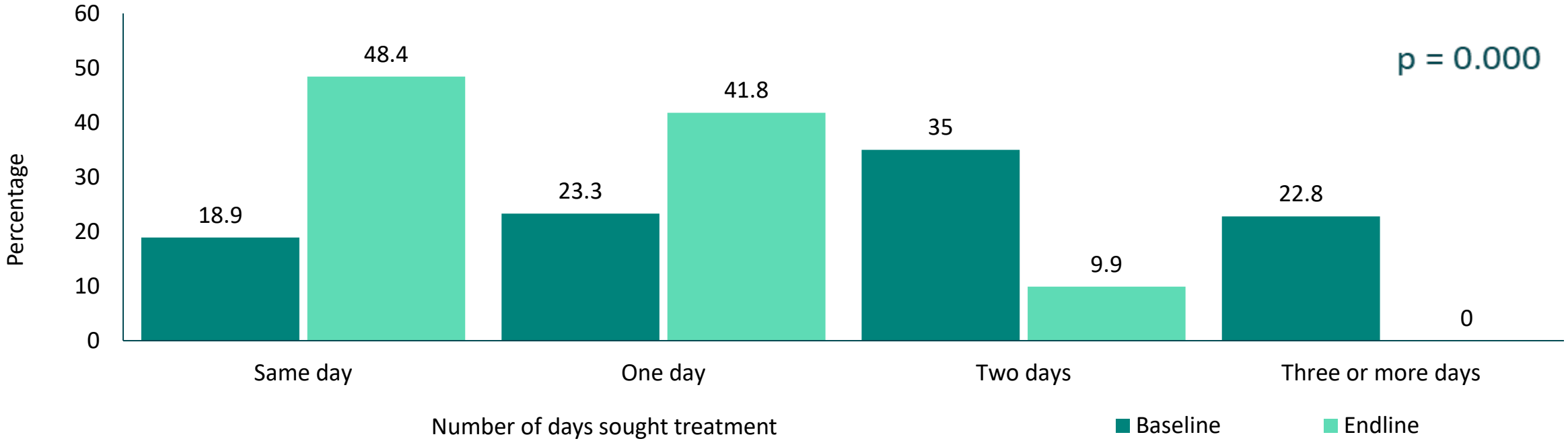
Endline: 2,407 (96.0%) ($p<0.05$).

Primary treatment sources

p = 0.000



Number of days before treatment for childhood fever sought



Baseline: 222 (18.9%) sought treatment for child after fever began on same day; 273 (23.3%) after one day; 411 (35.0%) after two days; 268 (22.8%) after three or more days.

Endline: 226 (48.4%) sought treatment on same day, 195 (41.8%) after one day; 46 (9.9%) after two days.

How we maintained CoHPA meetings and attendance of IDPs

- Coaching and follow-up with community volunteers and community leaders
- Field supervisors worked with community volunteers and leaders
- Scheduled repeated meetings
- Vouchers and incentives
- Field supervisors developed strong relationships with community/managing stakeholders, upholding reputation of organisation and building trust
- Community-based adaptations needed to maximise reach and adherence
- Understanding that displacement varies by context. It takes time to reach all displaced, and distance and fears of meetings sometimes prevent access.

Challenges and reflections

- Flipcharts and manual are good but can be hard to read for all participants
- In Myuka, the CoHPA scorecard was a difficult concept to learn, and the process took time
- Voucher reimbursement must be timely
- Drug delays were a critical barrier
- Rumour tracking could assist
- Vouchers may not be sustainable and the success of CoHPA is somewhat reliant on assistance
- Cash subsidies and drugs at the community health worker level are essential to ensure universal healthcare: “We are short of drugs. At times we test, and we have no drugs.”

Quotes on participation

Men — Myuka mid-term review

"This information is new to us; we have never had anything like this."

"I never used the nets because I complained of heat, but when I used for a short time, I noticed the difference and noticed mosquitoes no longer bite me."

Women — Myuka mid-term review

"These meetings are good as they help us clean our community and learn about malaria."

"We have the right to speak freely like anyone else in the meetings."

"Every voice is heard in the meetings and our ideas are not pushed aside."

Lessons learnt

- People appreciated the **regularity and community-led and owned nature** of the CoHPA process. People preferred discussing and support to find their own solutions.
- **Meetings and action plans require incentives**. The programme required more investment.
- **Further adaptations are needed for conflict areas** to meet the specific needs of families living in forests for farming work, and the specific behaviours and engagement with the programme by men and women.
- **Not all activities were completed in highly insecure areas** where meetings were too difficult and health services too poor for vouchers to have value.

Lessons learnt

- Vouchers were well received but **co-morbidities need to be considered** in future.
- **CoHPA could benefit from being integrated into wider programmes**: HIV, child health, maternal and reproductive health.
- **Community dialogue approaches are effective in conflict settings**, benefitting from strong investment in community training and leadership. They require regular monitoring and reviews to support adaptation but are typically underfunded.
- **Cash assistance is effective** if supported with consistent drug supplies and quality supervised care.

Conclusions

The project helped to increase the coverage and quality of community-based management of malaria within communities.

The project interventions are largely feasible and acceptable among the target populations.

Working with the local councils to make sure the strategies of the projects are incorporated into the municipality long-term plans will improve the programme.

Training community leaders and community health workers to manage CoHPA will enable sustainable support to volunteers.

THANK YOU

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