I. Kamara and K.T.B. Sedoh, 2006
Malaria Competence Network collaborates to roll back malaria.
Knowledge Management for Development Journal 2(3), 136-140
www.km4dev.org/journal

Malaria Competence Network collaborates to roll back malaria

Ibrahim Kamara and Komlan Toulassi Blaise Sedoh

> *I knew of the existence of malaria and how to treat it. But, now that we have self-assessed ourselves, all those breeding places of mosquitoes will no longer exist at my place*. (A mechanic in Togo)

Mombasa group

A facilitation team known as the Mombasa Group was formed in the summer of 2005 to share and support one another while implementing the malaria competence process. Members are from malaria affected countries in Asia and Africa, namely Thailand, Cambodia, Benin, Cameroon, Democratic Republic of Congo, the Gambia, Guinea Bissau, Kenya, Nigeria, Rwanda, Sierra Leone, Tanzania, Togo and Uganda. They comprise community workers, representatives of ministries, and staff from national malaria control programmes, United Nations (UN) agencies, faith based organizations and national and international non-governmental organizations (NGOs). Their goal is to develop malaria competent societies, where vulnerable people stop seeing malaria as a fact of life, and take the lead in fighting the disease. Facilitators help local communities to assess and use their own strengths to 'roll back' malaria and to connect with other communities in order to share and learn from their respective actions. Participating communities are making a greater use of available resources such as bed nets and malaria medicines. One year after introducing this approach, the evidence of its potential impact is growing.

In July 2005 , following an initial workshop in Mombasa where facilitators were trained in the approaches and tools to fight the disease, members joined an e-mail discussion forum and electronic library that facilitated continued exchange and learning among members of the group. After the workshop, all participants returned to their countries equipped to implement the malaria competence process in their communities and started influencing their own organizational policy.

The e-mail discussion forum is being used extensively, not only to encourage each others' efforts, but also to exchange good practices, for example on the impregnation of bed nets or strategies for bed net distribution. Lessons learned are captured in so called 'knowledge assets', which summarize common principles for action based on experiences and available resources for others wanting to know real-life solutions or to adapt those principles to their own context.

I got involved in the malaria competence process in June 2005 during the Health for Peace Initiative (HPI) meeting in The Gambia as a participant. I facilitated a training of trainers on the malaria competence process in my country and have since supervised the implementation of the self assessment tool in various communities and groups in The Gambia.
(Mrs. Adama Jagne Sonko, the Gambia National Malaria Control Programme)

As a result of this knowledge and advocacy initiative, malaria competence processes work towards rolling back malaria by recognising and acknowledging malaria as a disease that can be treated and prevented. Communities no longer accept malaria as a fact of life. In Gambia, Sierra Leone and Tanzania, communities are increasing uses of Insecticide Treated Bed Net (ITN). Determined to reduce avoidable disease and death, they are implementing a multi-pronged strategy for preventing malaria and treating the disease.

In order to succeed, the global partnership must mobilize the energies of millions of people acting locally to recover the terrain left to malaria. But a huge potential too often remains untapped: that of communities taking on the challenge and sharing their experience with others.

Communities self assess their strengths

The Mombasa Group proposes specific processes to bring together facilitation teams in order to learn from each other about ways of appreciating local strength, self-assessment, and capturing and sharing knowledge from experience. Through this process, communities are encouraged to address the issue locally, to mobilize the support they need to make an impact, and to share their experience with other communities. Facilitators transfer lessons learned to their own institutions, thereby enabling the policy changes required for accelerating and deepening impact.

The process is simple, and can be shared with communities nationwide to obtain faster, significant and sustained impact. Communities assess their level of competence on 14 key practices on a scale of one to five (one being the least and five the highest). They identify their strengths and where they want to learn. They take action to reach their targets. Communities can then compare their performance for each practice with others and share and learn from each other.

The approach has proved to be efficient and user friendly. Communities assessed themselves, discussed their own issues and set themselves targets towards the improvement of certain priorities including key practices in malaria prevention and control in their respective communities.

First results: a real impact

The Mombasa Group has further identified the following impacts:

- Change of mindset;
- Increased local ownership;
- Increased knowledge on malaria prevention and control;
- Recognition of vulnerable groups in the control of malaria, particularly children under five years and pregnant women;
- Increased access to treatment and use of ITNs;
- Increased preventive treatment for pregnant women; and
- Increased partnership.

For instance, the Village Health Committees in Kenyan villages started strengthening their service delivery systems after their self assessment and setting of targets for themselves. They selected community-based distributors to distribute ITNs to community members rather than just depending on the health facilities. In Zanzibar, Tanzania, the KATAA Malaria Initiative is greatly increasing knowledge about malaria. In Falakula village in the Gambia, an elderly woman who is part of the traditional communicators promoting malaria competence in their community noted:

> *Now we hardly get malaria cases in our families because we know what to do, we are using ITN which we know how to re-treat, and where we have malaria cases especially severe cases, we immediately take them to the nearby clinics. Our children are therefore no longer dying of malaria in Falakula.*

In Bonthe in Sierra Leone there are plans to get 100% ITN coverage for all children under five through a countrywide measles-malaria campaign, and in The Gambia, Tanzania (especially the Jambiani community), and Mali (especially in the Kita District) effective partnership and integration has resulted in 98% ITN coverage for all children under five.

After a self assessment meeting in Séva, a village in Vo district, Togo the chief decided to nominate a *gongonneur*. Every day, when the bell rings in the village at 6pm, everyone must go and hang his/her bed net. Health clinics have reported a marked decrease in the incidence of malaria in Zanzibar, Tanzania, with the completion of the first phase of an Indoor Residual Spraying (IRS) campaign.

Introduction of women's groups acting as traditional health educators to promote malaria competence in the Gambia, such as those in Kunkunja village, has greatly rejuvenated community sensitization on malaria prevention and control.

In Sierra Leone, a country proposal was developed with support from the Mombasa Group members and shared with colleagues and partners through the malaria competence e-platform which AWARE-RH (Action for West Africa Region-Reproductive Health) also has access to. Through this link, AWARE-RH showed interest and has since then followed-up with Sierra Leone on their malaria competence country plan. The organization is now supporting learning and sharing of good practices and experiences between Sierra Leone and the Gambia.

With malaria competence, communities are using their own resources and also accessing other resources to achieve more and have plans for the future. Face-to-face learning, sharing and transfer has been taking place between countries such as Guinea Bissau and Benin; Sierra Leone and the Gambia; Sierra Leone and Cameroon; Sierra Leone and Tanzania, and Togo and Cameroon. This has inspired many people or countries in the group to improve their own malaria activities in a move towards rolling back malaria.

Challenges
There are still some barriers and challenges that need to be overcome:

- Refusal to change mindsets such as: the conviction that malaria is a fact of life; holding on to the expert-knows-all mentality, especially among practitioners. In some cases communities recognize that malaria is a problem but still depend on others to come and take action for them;
- Lack of good facilitation of the competence process;
- Not enough documentation of the experiences, successes and changes. For example, measuring change and highlighting success in rolling back malaria helped facilitators realize that 90 instead of 9 people are using ITN in Kunkunja community in the Gambia. In the Jambiani community in Zanzibar, there were only 5 cases of malaria in one year out of a population of 5,137 (0.09%) in a country where malaria accounts for about 35% of all outpatient consultations. Documenting such achievements motivates communities to do more.

Conclusions

By using this process, the Mombasa Group has learned that malaria competence is contagious. Everyone has a contribution to make locally once they are given the opportunity and confidence to own the process. Malaria competence helps people to know their strengths and areas to improve. It relies on building on existing community potential, and involves learning, sharing and transfer of experiences and good practices within and outside institutions, communities, countries, regions and globally. It builds local communities' capacity and confidence, and provides necessary support to claim ownership of malaria prevention and control interventions in their areas. By so doing, they work towards rolling back malaria in their respective communities, countries, regions and the world over.

Abstract
This story charts the path of a facilitation team known as the Mombasa Group which was formed in the summer of 2005. Its goal was to develop malaria-competent societies where vulnerable people stop seeing malaria as a fact of life, and take the lead in fighting the disease. With malaria competence, communities are using their own resources and also accessing other resources to achieve more and have plans for the future. Face-to-face learning, sharing and transfer has been taking place between countries such as Guinea Bissau and Benin; Sierra Leone and the Gambia; Sierra Leone and Cameroon; Sierra Leone and Tanzania, and Togo and Cameroon. This has inspired many people or countries in the group to improve their own malaria activities in a move towards rolling back malaria.

About the authors
Ibrahim Kamara has worked with Government, World Vision and since 1994 with Plan Sierra Leone in the area of HIV/AIDS and malaria prevention and control. His specialization is in community involvement. Since 2006 Kamara is a coach for the Constellation for AIDS Competence [www.aidscompetence.org]. He coordinates the malaria competence process in Sierra Leone and The Gambia and helped strengthening the process in Tanzania and Cameroon.
E-mail: Ibrahim.Kamara@plan-international.org

Komlan Toulassi Blaise Sedoh is the national HIV/Coordinator of the Togo Red Cross.
E-mail: blaise.sedoh@gmail.com