Feasibility testing of a community dialogue approach for promoting the uptake of family planning and contraceptive services in Zambia

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Abstract

Background Community dialogues have been used in various participatory approaches in various health prevention and awareness programs, including family planning interventions to increase understanding and alignment of particular issues from different peoples' perspectives. The feasibility testing comprised of the implementation of a community dialogue intervention which generated discussion on key issues that needed to be addressed to decrease the unmet need for family planning- in this instance improving Quality of Care; and an evaluation thereof. The aim of this paper is to document the evaluation of the feasibility testing of a community dialogue approach, as part of formative phase research, in order to increase community and health care provider dialogue about family planning and contraceptives. Methods The operational and cultural feasibility of the community dialogue was evaluated through participant observations during the dialogue, using a standardised feasibility testing tick-list, and through focus group discussions with three different groups of stakeholders who participated in the community dialogue. Results Overall, 21 of the 30 invited participants attended the meeting. The approach created dialogue on family planning and QoC as per the objectives of the feasibility testing. There was a dialogue about how the quality of care could be achieved in family planning from the divergent stakeholders, guided by the agreed-upon ground rules. A need for more time for discussion and representation from the adolescents and other stakeholders in family planning such as the nutritionist was noted. Some participants were not comfortable with the language used, while others felt the other participants had more knowledge about the topics discussed. Conclusion Generally, the community dialogue was well received by the community members and the healthcare providers, as was seen from the positives sentiment expressed by both categories. Some key considerations for refining the approach included soliciting maximum participation from otherwise marginalized groups like the youths would provide stronger representation.

Introduction

At the London Summit for Family Planning in 2012, participation was appreciated as a key principle in ensuring that the target to provide family planning access to 120 million additional women and girls by 2020 is met [1]. The community plays an important role in reproductive health; as such, community-based participatory approaches involve an understanding of strengths and weaknesses among all the parties involved, each party aims to solve, by combining knowledge and action for social change, in order to improve health and eliminate health disparities [2]. Participation is defined as the active involvement of affected populations in decision-making, implementation, management and evaluation of policies, programs and services [3].

Community dialogues have been used in various sectors as a participatory tool to encourage a common mutual understanding and realization of perspectives and conditions of the other person or party, in order to identify and prioritize the needs of the community [4–7]. The dialogues are meant to bring together parties that would not normally collaborate and assists them in aligning their thoughts on a particular issue [8]. A community dialogue forum allows for existing knowledge from each party to be increased

with the perspectives and views of others, and issues can be discussed and debated on in a neutral environment that allows for a fair exchange of ideas [9].

Community dialogues have been most commonly used, but not limited to the context of HIV and AIDS prevention and care as well as in mental health [10–13]. However, this paper reports the use of community dialogue in Zambia, in efforts to improve uptake of Family Planning and Contraceptive (FP/C) services, which have previously been undertaken mostly in West Africa [14]. Such an approach can also be applied in other sexual and reproductive health areas such as maternal and child health and adolescent health. Though others have reported the outcomes of community dialogues, this paper focuses on actual implementation and how it can be improved, in order to make it more applicable in other health sectors.

The UPTAKE Project aimed to test whether a community participation programme involving health care providers and the community, could increase the met needs for FP/C in the community. In the context of the project, the methodology through which healthcare providers and the community were to be engaged was referred to as “The Approach” [7, 15].

The Approach was developed through well-informed evidence from existing literature [16] and refined through the integration of community, healthcare provider, and other stakeholders’ perspectives using qualitative research activities: focus group discussions (FGDs) and in-depth interviews during the formative phase of the Project [17]. The Approach defines best practices that address four stages in the implementation of a participatory programme: (i) programme initiation, (ii) participant identification and recruitment, (iii) ensuring community and health system dialogue and collaboration, and (iv) ensuring sustainability and scale-up [15].

The feasibility testing of the Approach focused on stage (ii) and (iii), which involved participant identification and recruitment and ensuring community and health system dialogue and collaboration, and consisted of determining the operational and cultural feasibility. The Approach proposes three minimum required categories of participants that include community members, health providers, and other stakeholders such as key organizations/groups working in reproductive health or individuals/community members who are considered influencers in FP/C decision-making.

The approach used a community dialogue methodology that was structured following a Theory of Change (ToC) framework to encourage community and health system dialogue and collaboration. In other words, the ToC framework served as a participatory tool to engage both community and health care providers to discuss and define possible pathways toward an overall outcome, which was to address the unmet need for FP/C and then collaborate to achieve them.

There is limited documentation on the process of testing the operational and cultural feasibility of community dialogues; therefore, this paper outlines the process of testing the operational and cultural feasibility in bringing together health care providers and the community to participate in a community dialogue. The feasibility testing was done with QoC in FP/C services as an entry point to the discussions.

Early in the formative phase of the UPTAKE Project, QoC was identified as a key intermediate outcome that could lead to increased met needs. This was based on the assumption that quality services that responded to the needs of the users and potential users were a requirement for increased demand and utilization of services. Further considerations were integrated into the approach following the feasibility testing and finalization of the formative phase research.

Methodology

Establishing the feasibility of the approach was undertaken in two ways:

Conducting key stages of the community dialogue with representations from the community and health providers. The evaluation of the feasibility testing of the approach was done through observations using a standardized feasibility testing tick-list for all observers of the dialogue which included sections representing the whole dialogue process and through FGDs with three different groups of stakeholders who participated in the community dialogue (health care providers only, community members only and mixed group of health care providers and community members).

Conducting the feasibility testing of the approach: community dialogue
Recruitment

The invitees for the community dialogue were a combination of people from the three main categories; community members, health care providers, and other stakeholders in FP/C to endure equal participation and representation (Table 1). Recruitment of participants was facilitated by the local district medical officer, who engaged the nursing officer at the district level. The officer was in charge of the entire recruitment process of health system representatives, inclusive of nurses, clinical officers and other FP/C practitioners. The categories of participants that the nursing officer recruited also included the community (volunteer) health systems representative groups such as the Safe Motherhood Action Groups (SMAGs), the neighborhood health committees, the community members FP/C users and the adolescents and representatives from the youth-friendly corners.

Apart from the health care providers and community members invited to the meeting, other stakeholders in FP/C were also invited. These included the Non-Governmental Organizations (NGOs), the government teachers through the District Education Board Secretary (DEBS) and the District Commissioner representatives (DC) - who unfortunately was unable to attend the meeting. In all, of the 30 people who were invited, 21 managed to attend the dialogue, meeting the 70% minimum requirement that was agreed upon by the project team.

Table 1: List of invitees for the Community Dialogue

	Participants categories	Invited	Confirmed	Attended
Community members	Community Members (Including Community Health Committees and users)	6	5	5
	Adolescents	3	2	2
	Community Leaders	3	0	0
Healthcare providers	Health Care Providers- Managerial	5	4	4
	Health Care Providers- Frontline	7	6	6
Other stakeholders	Teachers	2	2	2
	NGOs	4	3	2
	Total	**30**	**22**	**21**

The dialogue

The community dialogue was conducted in a suburban district of the Lusaka and that this site was not one of the sites where the intervention was planned to take place. The entire dialogue session took a total of 125 minutes, with a 20-minute break. The dialogue session was divided among three facilitators who were project staff members. The first section gave a detailed background to the project, its goals, and the aims of the community dialogues. This activity lasted a total of 20 minutes. The participants were then asked to suggest the ground rules that they felt would guide the discussion during the community dialogue. Reference was made to these ground rules throughout the dialogue session as was agreed upon by all the participants. The suggestions on ground rules took about 15 minutes.

After setting the ground rules, the first facilitator presented the ToC to the participants in very simple terms. This part aimed to show the participants exactly how the discussions would lead to the overall outcome, which was to reduce the unmet need for family planning. To explain further how the ToC was going to be used, a simple exercise was done. A discussion, led by the second facilitator, was introduced to identify the steps and pathways to improve QoC. More pre-suggested intermediate outcomes were then discussed, and for each outcome, the activities and assumptions were discussed too. The intermediate outcomes included having qualified health workers, availability of preferred methods at the health facilities, having more respect for clients and having more equipped family planning areas. This activity took about 60 minutes.

Once the pathways, activities, and assumptions had been identified, the third facilitator guided a discussion on identifying the most feasible and acceptable pathways with regards to acceptability, demand, implementation, practicality, adaptation and integration. This criterion was based entirely on each participants' opinion and they were encouraged to speak freely and decide on which pathways they thought would be best to achieve more than one intermediate outcome. This activity took about 90 minutes. After the discussions using the ToC participatory tool had been concluded, the first facilitator then gave a brief summary of the entire community dialogue activities and thanked the participants for their invaluable and active contributions throughout the discussions (Annex 2: Agendas for community dialogue meeting).

Evaluation of the Community Dialogue

The evaluation of the approach was done through FGDs and observations.

Focus group discussions

Following the community dialogue session, three FGDs were conducted in order to hear from the participants, how the entire program was handled. The facilitators used a pre-defined guide to structure the discussion. The FGDs explored the following themes; representation in the community dialogue, orientation and ground rules, participation in the community dialogue, a dialogue on FP/C and QoC and technical, schedule, and cultural feasibility of the Approach. The FGDs, as a form of participatory evaluation, allowed for the participants to air their views on each of the themes.

The participants of the community dialogue participants were split into three groups for the FGDs: the community member group, the health care provider group, and a mixed group with both the health care providers and the community members. The groups were split so as to ensure ease of discussion among the group members and they were allowed to be in any group provided it was the right category. Feedback was obtained through these discussions. Not all the participants of the dialogue were part of the discussions as they opted not to, or had to leave and attend to their personal work. Each of the focus groups had at least 5 participants. The process of informed consent was fully adhered to.

Observations

Non-participant observations were also used as a data collection method for the evaluation [18], where people who were not participants of the community dialogue were selected to observe the entire session. This was done to get a broad overview of the setting, as well as the entire community dialogue process being undertaken by the project team. The three people carried out guided observations while the community dialogue was taking place using a standardized feasibility testing tick-list (see Annex 1). The observations were done by; a project team member, a health system representative and a community member to ensure that diverse views were captured. The health system and community representatives were only taking part in the project for the first time while the project team member was more aware of the objectives of the community dialogue activity. This was done to control for the observer effect [18]. The three different types of observers were selected in order to control the selectivity that can occur when only one type of observer is used [18].

Data analysis

FGDs were audio-recorded, with participant permission, transcribed verbatim, and translated where necessary. A qualitative data analysis software program, NVivo (Version 10, QSR International), was used to organize, code, and analyze the data. A code list was developed based on predetermined themes adopted from the key areas the feasibility testing was interested in investigating. Participant observations were noted during the dialogue by project team members and this enabled triangulation of findings from the FGDs. The three observers' findings were also read, aggregated from the community dialogue tick-list and these findings were also used for triangulation of the community dialogue report.

Ethical Considerations

The process of informed consent was fully adhered to. The informed consent components were discussed with the group, and individual written consent was obtained from each of the participants by members of the UPTAKE Zambia team, the Principal Investigator, Research Assistant, Data Manager and the Facilitators. All participants were over 18 years and no assent was required. The entire study, including the feasibility testing was reviewed by the WHO technical and ethics review boards (A65896) and local ethical clearance for the study was obtained from the University of Zambia Biomedical Research Ethics Committee (UNZABREC) and permissions to work within the Zambian health system was sought from the Ministry of Health.

Key Findings

The findings in this section include the results from the FGDs and participant observations under the following headings; recruitment and identification (attendance), orientation and ground rules, participation in the community dialogue, the dialogue of FP/C, and QoC and technical, schedule and cultural feasibility.

Recruitment and Identification

Overall, 70% of the people invited attended the meeting. Among the participants who attended the meeting were health workers, community members, including adolescents and other stakeholders such as the teachers (Table 1). Some of the other stakeholders who were invited neither attended the meeting nor gave apologies for not attending the meeting.

During the FDGs, while some health care providers felt that there was adequate representation in the community dialogue, the community members mentioned that for the dialogues to representative enough and produce relevant results, there was a need to broaden representation further. For example, there was a need for political leaders also to be represented. The community members also mentioned a need for representation from the home and faith-based organizations as it was recognized that they play an important role in society. The community members also stated that the Community Health Workers were well represented, but that the pharmacists were needed to bring out more information on the vastly experienced stock-outs of FP/C supplies.

"We were not represented properly because were outnumbered, others were more, but we were just a few of us…"

[Community focus group discussion, Adolescent]

"I think to be specific, we should have some representatives from churches, yes, and from the political wing, the stakeholders they should have called them because they are part of it (the problem) as well."

[Healthcare provider focus group discussion, Healthcare Provider]

From the observations, it was noted that the adolescents' turn-out was less than the intended number (2 out of 3). Most of the people who did not attend the meeting were from the community, while almost all the health care providers invited attended the meeting.

Orientation and Ground Rules

At the start of the dialogue, the participants were encouraged to suggest ground rules to be observed during the entire dialogue. Ground rules for the dialogue included: respect for people's opinions, to speak loudly and clearly, to set phones on vibrate or silent, to raise hands if they wanted to talk, no side meetings, to participate actively, to stay on topic, to acknowledge all are equal in this group, that no one would reveal anyone's opinion after the meeting.

During the dialogue, there was consensus by the participants that ground rules were appropriate because they all took part in creating them. All the participants were able to remind themselves and each other to follow the rules throughout the discussion. As such, they appreciated the importance of the rules in maintaining organization and order throughout the meeting. One of the youths, among the community members, on the other hand, felt that the rules should have been explained better for him to understand better what they meant. It was assumed that all the rules were understood because they came from the participants. Some participants had this to say:

"They (ground rules) came from the participants, it was not imposed on the participants, but it's the participants that came up with those rules."

[Mixed focus group discussion, Healthcare Provider]
"I did not understand the first one, the one that says speak through the chair, and do you speak alone or…?"

[Community focus group discussion, Adolescent]
Participation in the Community Dialogue

The preferred language to be used during the dialogue was discussed. During the dialogue meeting, there was consensus that English was appropriate for the discussions. Health care providers, community members and other stakeholders all agreed that it allowed for proper articulation of ideas by participants, whether they were from the health sector or not. Some community members during the FGDs mentioned they could have expressed themselves better in the local language despite agreeing to use English during the dialogue session. Other members of the community felt as if the discussion was specialized, especially when the health care providers spoke. The use of technical language and abbreviations during the dialogue was discussed during the FGDs. With regards to the presentations, community members indicated that where some acronyms they did not understand, hence on some occasions, they could not answer appropriately.

".. the language; it is not everyone that has been to school or up to grade12, at least there was supposed to be a mix up of language with English because some of us work in the community and we use local languages. So somehow to some of us, some words were big."

[Community focus group discussion, Community Member]
The youths also said during the FGDs that they felt that English was appropriate, but some of the terminologies and acronyms were too complicated for them to understand but felt too shy to ask what these meant. Some of the other community members agreed that the youth were unable to ask what the terms meant and so they tried to enquire from their neighbors in the meeting and not through the moderator.

"Like the term 'integration', that term yes was not clear."

[Community focus group discussion, Adolescent]

"Oh yeah, okay they (terminologies) were coming from us participants and some community health workers because those are normal terminologies, but it might have been different from teachers, those are not like, this man (name mentioned) am sure he is very aware of them, but there are community workers who are from teaching maybe like my son here, the adolescent, he is not familiar with those terminologies."

[Healthcare provider focus group discussion, Healthcare provider]
From the observations and interviews, community members participated well in the community dialogues despite being outnumbered by the health care providers in the meeting. Overall, both the community members and the health care providers, as well as other stakeholders, reported during the FGDs that they felt free to speak their minds and participate as this was reinforced by the fact that they were no wrong answers; one of the ground rules. One health care provider had this to say:

"I feel there were no barriers because people were able to express whatever they wanted to say and no one was opposing even when the answer that one gives or opinion that one gives was not opposed…"

[Mixed focus group discussion, Healthcare provider]

"Actually it was something that was good, it is important once in a while to meet together with the community and the health providers because, for health providers, there is nothing that we can do without the community, cause or anything sensitization and other things we depend on the community so the community should be given information on everything that is there in the health facility. So we are represented, it's a link actually between the community and the health Centre, and so these representatives are important to us and the health providers because they are the ones who speak to us and whatever we want from the community we ask these people to speak for us."

[Community focus group discussion, Community Members]
From the observations, it was seen that the adolescents also expressed themselves by bringing out issues that affect their access to FP/C information and services but with active encouragement from the facilitators because the youth felt very uncomfortable speaking out as they felt that there were too many adults in the meeting compared to adolescents. Other stakeholders invited, such as the NGO representatives, brought out dynamism to the discussion and even suggested integrating FP/C into other services such as HIV care.

Dialogue on FP/C and QoC

Despite feeling that the health care providers were more familiar with the topics under discussion, the community members were able to bring a their own perspective to the subject of QoC in FP/C, with particular reference to the ones representing the education system, who brought out the moral issues relating to providing sexual and reproductive health information and services to the youth, especially those who are still in school.

"I think it was okay, we have interacted freely, openly and we have understood each other's views, and from this, I think we are picking a leaf for forward (to move forward) in life"

[Healthcare provider focus group discussion, Healthcare providers]
All the participants also agreed that access to FP/C information and services was quite vital. They were in agreement that this was an area that needed to be deliberated on so that overall unmet need could be reduced. They also mentioned the benefits of FP/C and that there was more work to do regarding sensitizing the community about the different FP/C options they have. They also made specific reference to the need for information among the youth.

"I would concur with her because of the unwanted pregnancies mostly, and they end up to have unsafe abortions, so if the services given to these adolescents, I think it will prevent the abortions and unwanted pregnancies among the youth."

[Healthcare provider focus group discussion, Healthcare provider]
While the Approach was accepted, some of the participants from the education sector had some reservations, especially regarding sharing FP/C information with the youths. They felt the youth are too young for all information and that it needed to be altered to make it more appropriate for the youths. Without this censoring, the information was seen to increase the rates of promiscuity among the youth. They also mentioned that the Approach was not very acceptable by the religious community, though none of them was represented in the feasibility testing.

"I feel it cannot be applied especially in the religious context, for instance, if the girls are introduced to using family planning, it is like you are telling them to start engaging in sex, whereas religious in the bible, it is talking about those children not to start engaging until they get married. So if you give them contraceptives, it is like you are telling them to go ahead and have sex."

[Mixed focus group discussion, Health Care Providers]
All the participants agreed, during the dialogue and the FGDs, that they were able to learn from each other, and they agreed that they had different viewpoints concerning QoC (health care providers and the community members: supply and demand-side views) and that these were discussed. For example, the lack of certain services such as the Intra-Uterine Device was due to staff shortages and not negligence on the health care providers' part.

"I would say it was good because there were some divergent views before we could come to agree because we were also given opportunity to argue, and try to raise up some concerns, challenges that we need, and also what the community is complaining, but at last we agreed to say we have to work together, we need to prioritize our systems and working so that both of us benefit."

[Community focus group discussion, Community Member]
Some strong differences in opinion about QoC were noted between the community members and the health care providers. During the FGD discussion, participants concluded that they were looking at QoC, but from different perspectives—the supply side and the demand side.

"Yes I think this was a very good discussion, this one has helped since we have people from the district office: education, it will help them plan, how can we get out there to the children, how can we reach them with this information and we also heard their blocks/obstacles and all this. So we didn't know as health providers that we also have a limit. We thought it was easy for us to go and talk about sexuality openly in their schools. So I think it was a very good thing that at least even as health workers will know how we are going to take it when we meet a child who is ours and will not behave like a parent but as a health service provider…"

[Mixed focus group, Healthcare provider]
With regards to the importance of the discussion on QoC, the community members reported during the FGDs and the actual dialogue that they were able not only to agree on the definition but also to identify the key constitutes of QoC as highlighted by all represented categories of participants. In short, they could explain what they thought should constitute QoC even though defining it was a challenge compared to the health care providers and the other stakeholders invited.

"It was useful such that it kind opened up on how the people in the health centers talk to the adolescent when they come to ask for help from them like if you want to ask for a condom, they shouldn't go like as young as you are and all."

[Community focus group discussion, Adolescent]

"I think we did agree on what Quality of Care is as a community and the health care providers and that's the more reason why we came up with those terms, yes we were very free to express ourselves and even

after expressing ourselves although seemingly we were putting the health provider in a squeeze position but no it was so nice that at least both parties were able to understand, where each one of us is coming from and then at the end of the day we fully realized how important and the stressful conditions that this other person is in."

[Mixed focus group discussion, Healthcare providers]

Schedule Feasibility

During the FGDs, some of the community members indicated that time was insufficient for the discussion as they should have been given more time to allow exhaustion of the opinions and ideas from each and every one of the participants, on the key issues that were raised in the dialogue. Some participants also felt that there was a need for more time to be allocated to the discussion because, in the beginning, not all the participants had understood that part of the activity. So once everyone was on the same page, the discussion became richer. While some felt the time was insufficient, others thought the duration of the meeting was seen as appropriate as there were two health breaks during the whole dialogue session, allowing for participants to be refreshed.

"The duration of the meeting was …we needed to be here for two days or so."

[Community focus group discussion, Community Member]

"Yes, I think it was ok except that other people dominated the floor, and I feel other people would have also benefited to make their views known but some people took most of the time."

[Community focus group discussion, Community Member]

The observations revealed that it was most difficult to get people acquainted with the subject matter. After the participants were more familiar with the entire dialogue process and what needed to be achieved, the meeting became more interactive. This, however, had an impact on the time allocated to some of the activities, especially those which required discussions among the participants. These included the ground rules session and the session where they were required to select the most feasible pathway.

Cultural Feasibility

With regards to the Approach, all participants felt it was culturally sound because all the participants were interested in reducing problems associated with unmet need for FP/C. However, with this in mind, community members and health care providers further added that there was a need to include other members of the community in order to determine further cultural acceptability of the Approach. If more people from different sections of society were brought to share their views, then the cultural acceptability would be clearer.

"The approach was quite okay like we are saying, we know society is dynamic and we move with time and trends that we have previewed at that particular time, but am sure like we heard from the young man, he said he could not come so easily because he was amongst the elders, because our tradition says that they are certain things that we can easily mention in the public, others we cannot. Although in this forum, it wasn't coming out like hinting so much on our tradition."

[Community focus group discussion, Community Member]

Technical Feasibility: Use of visual aids during the community dialogue

In the FDG, all the participants agreed that the aids used during the dialogue session, the flip chart and the one-pager documents with information of QoC and the unmet need for FP/C were useful, especially when it was time to discuss the different pathways, activities and assumptions. The participants also felt that the aids used were able to open up their minds and give them even better ideas about what would or would not work. Community members and health care providers were able to understand more about what the aim of the dialogue session was, particularly those who joined the meeting later. The tools used were able to achieve desired dialogue, though more time would have been more beneficial in discussing the pathways to achieving QoC in family planning and contraceptive services.

"I am talking in terms of how the program started because we were using PowerPoint we were able to see the definition, we would start by introducing the background of the project itself, we learnt that the project is running in three countries so we were able to understand… ."

[Healthcare provider focus group discussion, Healthcare providers]

Discussion

This paper aimed to document the feasibility testing of an approach bringing together health care providers and the community to participate in a community dialogue. Factors that influenced the implementation of the community dialogue during the community dialogue and subsequent evaluation through FGDs will be highlighted in this discussion.

Positive attributes of community dialogues

The participants generally agreed that FP/C were very important issues that needed to be addressed, despite coming from different backgrounds. They all understood that key issues around the provision of these services, as well as uptake in the community needed to be looked into and improved. Such success has been reported in other dialogues in suicide and HIV prevention as they aim to achieve a common understanding of the problem [10, 13, 19]. Dialogue ensured a shared understanding of the problem at hand and what needed to be done for that problem to be solved. They also mentioned that they learned a

little more than they knew about FP/C, a finding similar to the key driver on implementation in a study done by Tesfaye in Ethiopia on curbing HIV using community dialogues [11]. Currently, there is little evidence on participatory interventions in FP/C and the feasibility testing proves that this is a possibility that should be explored further [16].

Divergence in the categories of people invited enriched the meeting and allowed for increased representation from the community and from the health sector too, similar to what was found elsewhere [7]. The dialogue approach facilitated the engagement of the community and health care providers as it was viewed as feasible, despite cultural influences that come into play when dealing with FP/C. Having a forum or platform for the different stakeholders allowed for more understanding of the other participants' views, who they previously blamed for hurdles on service provision. There was a need also to be aware of the power dynamics [16], especially where the health care providers were more conversant with the subjects under discussion.

Regarding orientation and ground rules, the whole process was appreciated as this triggered and ensured ownership of the rules by the participants. They took part in developing the rules, so they did not feel like these rules were imposed on them by outsiders (facilitators). The rules were thus very acceptable as the role of the rules throughout the dialogue was also accepted and the rules were adhered to.

Considerations for refining the approach

Adequate representation ensures that divergent and varied viewpoints are considered and in the discussions, and a new shared understanding develops. The importance of representation from a wide range of stakeholders was also stressed in other community dialogues but this could only be addressed after an evaluation of the dialogue, and suggestions for more stakeholders were made [7, 10, 11]. A consideration for refining the approach was that of engaging religious leaders in the dialogue, to have more representation from a religious perspective.

There was also a need to gain insights from the actual users of FP/C services. In order to be able to increase representation, it would be better to allow the participants to mention who they felt needed to attend the meeting too. The participants were brought into the discussion as representatives from the community but not really as users, so these perspectives were missed in the discussion. During the preparations, efforts were made to identify various categories of stakeholders, however, more were suggested during the dialogue, amplifying the importance of the feasibility testing itself.

Allowing more time for the different participants to express themselves was suggested as people had more ideas and experiences to share as the discussion progressed. For more meaningful dialogue and understanding of the issues at hand, there was a need for more time to discuss the pathways to change. This is similar to Tesfaye's finding in Ethiopia [11], though this study had over 60 participants, which is over twice the number of participants in the feasibility testing. This points out to need to not be too liberal with the number of participants in the dialogue session and to be mindful of the time taken during the overall dialogue process [7].

The language, technical terms considerations needed to be considered more, as some of the participants may not have been as conversant with all the terminologies. Consideration of adding clear and direct language used during the ground rules section was made too. As much as it is not good to interfere, it would also be good to ask the participants to explain the terms they are using so that everyone can understand and keep up with the discussion. There was also a need for the facilitators to be multilingual as a way to show the participants that language should not stop them from taking part. Crankshaw et al. 2019 in South Africa found that bilingual notetakers during the dialogue process were very useful in facilitating language complexities. Studies to facilitate dialogue in HIV revealed that language was considered before the meeting, and all the facilitators were multilingual, according to the community targeted [11].

The facilitators of the community dialogue meeting also needed more training in using the ToC tool to facilitate the meeting. This would reinforce the importance of a capable facilitator to create the space for dialogue, ensure respectful expression of diverging views, and to fully understand the tools and the desired outputs of the entire intervention. In addition, the adolescents also felt that they were outnumbered by the adults.

Limitations and Strengths

One of the limitations of this feasibility testing is that it was a one-off meeting, and some of the other components of the approach were not tested during this meeting. However, the community dialogue stage was one very vital stage of the approach and very valuable information was obtained from the evaluation. Regarding the methodology, some aspects of observation may have brought out some subjective findings [18]. This was dealt with by selecting three different types of observers. Finally, while this feasibility testing was nested in a participatory approach that aimed to bring together health care providers and the community members in the intervention stage of the project, “the edge effect,” coined by Burton and Keagan (1999), was also achieved [20]. This means the community benefited from the knowledge and contact facilitated by the research project by meeting, talking and sharing information for mutual growth and benefit to members of the community.

Conclusion

The participants of the feasibility testing well received the community dialogue approach structured using ToC. Participants were able to speak freely and they had enriched discussions due to the diversity of representation during the dialogue. Despite coming from different backgrounds and having different viewpoints, this platform allowed them to agree on the importance of and have a shared understanding of the problem of high rates of unmet need. All participants suggested solutions that were acceptable to all the participants in spite of their differences. It is important to note, however, that certain factors need to be taken into consideration to yield more fruitful discussions. Great emphasis on language of choice ought to be stressed throughout the dialogues facilitated by multilingual people too. A need to look out for marginalized persons such as adolescents, in this case, is essential too. While ownership is increased

by allowing the participants to speak freely, there is also a need to remind the participants to reduce the technical jargon for greater ease of understanding.

Abbreviations

DC- District Commissioner

DEBS- District Education Board Secretary

FGDs- Focus Group Discussions

FP/C- Family Planning and Contraception

NGOs- Non-Governmental Organizations

QoC- Quality of Care

SMAGS- Safe Motherhood Action Groups

ToC- Theory of Change

WHO- World Health Organization

Declarations

Ethics approval and consent to participate

Written informed consent was administered and voluntary participation was adhered to. The entire study was reviewed by the WHO technical and ethics review boards (A65896) and local ethical clearance for the study, including the feasibility testing was obtained from the University of Zambia Biomedical Research Ethics Committee (UNZABREC) and permissions to work within the Zambian health system was sought from the Ministry of Health.

Consent for publication

Not applicable

Availability of data and materials

The data are not publicly available as it contains information that could compromise research participant privacy/consent. However, some anonymized aspects of the datasets may be available upon request and with permission of the Department of Reproductive Health and Research, World Health Organization. Note that data sharing is subject to WHO data sharing policies and data use agreements with the participating research centers.

Competing interests

The authors declare that they have no competing interests. The authors alone are responsible for the views expressed in this article and they do not necessarily represent the views, decisions, or policies of the institutions with which they are affiliated.

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Authors' contributions

The study conception and design was done by PS, JC and TN as well as the other principal investigators on the project from Kenya and South Africa. MM, TN and AS contributed towards data collection, MM and AS analyzed the data and MM drafted the manuscript. TN AS, JMZ, JC and PS contributed towards the revision of the manuscript. All authors read and approved the final manuscript.

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