

THE KNOWLEDGE DIALOGUES

METHODOLOGY



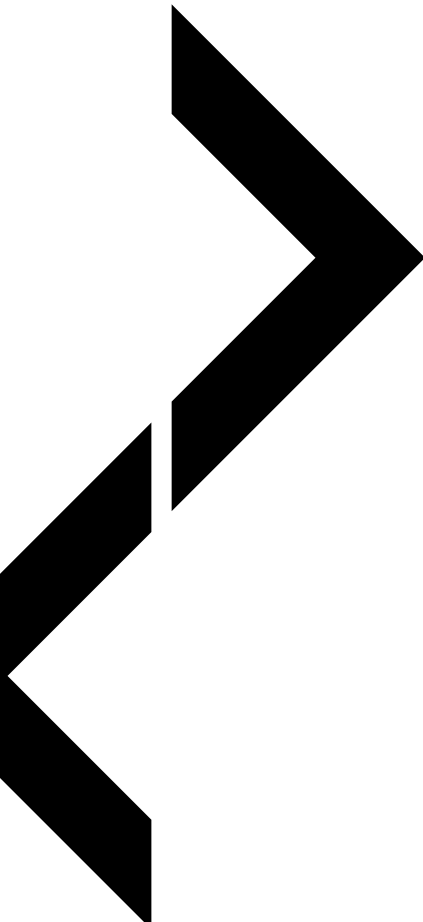
PAHO



Pan American
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WASHINGTON, D.C., 2022

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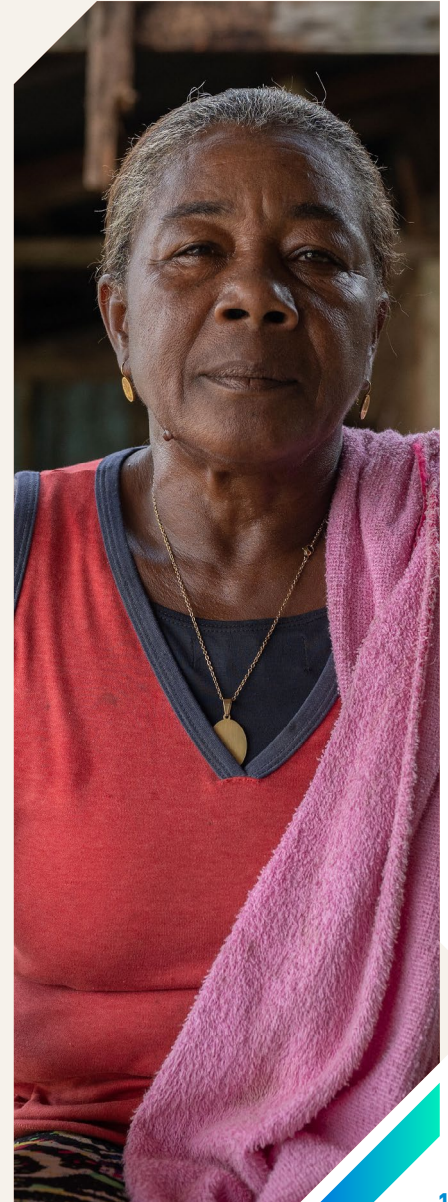
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INTRODUCTION

Knowledge dialogues form part of the richness of cultural diversity; among their purposes is to improve different groups' access to health services and build intercultural health. This document is aimed at professionals in the health field or from other areas who are seeking methodologies to learn about, share, and build healthy dialogue-based practices.

While the emphasis here is on the health sector and the diversity of ethnic groups, this methodology can be applied to any other sector, and to all kinds of population groups. The methodology is useful for establishing ties with myriad cultures and groups, through communicative actions. Although this document focuses on indigenous, Afro-descendant, and Roma people, the methodology can be applied to working with any other group (e.g., migrants, displaced persons, adolescents, or the elderly) who also experience problems with access to health and universal health coverage.

In its experience with technical cooperation, the Pan American Health Organization (PAHO) has observed that in countries of the Region of the Americas, intercultural dialogues have been positioned as one of the tools that can contribute to advances in achieving access to health care and universal coverage. This is especially true in those countries of the Region with health systems based on primary health care (PHC).





It is important to understand the cultural differences between countries, identify asymmetries in power relations, and carry out cultural and linguistic localization, when necessary; and also, to discern the logic behind the diversity of health systems (both Western and traditional), learn and achieve mutual understanding in the situations being addressed, manage agreements and disagreements, and consistently incorporate the results of knowledge dialogues into the implementation of health care models, with a family, community, and intercultural perspective.

The countries that have recognized these elements have successfully adopted knowledge dialogues as a tool contributing to the intercultural adaptation of health services, as well as changing behaviors and attitudes to guarantee the right to health with an intercultural perspective, and achieving the participation and engagement of health officials and ancestral therapists and healers.

PAHO is introducing this methodology of intercultural dialogues in the context and situations described, based on learning experiences in countries of the Region. The methodology is expected to lead to better health access and coverage, with a view to overcoming ethnic inequalities, inequities, and injustices in health—an approach that can be applied to other sectors and not focused solely on this area.



1

WHAT ARE
KNOWLEDGE DIALOGUES?



Knowledge dialogues, also called intercultural dialogues, are a process of communication and exchange between people and groups who come from different cultures or origins.

The starting point is respect for the opinions, beliefs, and customs of persons and groups that do not necessarily agree on the issues to be discussed, as they have different cultural, linguistic, religious, and ethnic roots.

The central tenet of knowledge dialogues is the recognition of a symmetry between the participants, without hierarchies. It is assumed that all knowledge has the same value and must be considered when building these dialogues. Putting this into practice is extremely difficult, as it means setting aside the interlocutors' positions of power.

A necessary condition for knowledge dialogues is to reassess and promote the different groups' knowledge, practices, and cultural expressions through each culture's transmission mechanisms. Thus, knowledge dialogues can help build a social consensus for the economic, social, and cultural improvement of communities and entire countries.

Applied to the health field, knowledge dialogues form part of an intercultural policy that considers it advisable and possible to combine traditional medical systems with the Western medical system. This should be taken into account not only regarding care for illness, but also in relation to health promotion and accompaniment of the dying. These dialogues promote respect for cultural diversity; they require recognizing and understanding communities' traditional and folk wisdom, and not destroying or infringing on them with Western medical knowledge.

1.1

CHARACTERISTICS OF KNOWLEDGE DIALOGUES

Knowledge dialogues are based on recognizing that what is true and valuable comes not only from science, but also from the popular wisdom derived from the cumulative experiences of many generations. What we call *popular wisdom* is an observation-based social knowledge that is handed down as a cultural legacy.

Knowledge dialogues are not a way to teach other people; rather, they are a form of *two-way learning*: a knowledge feedback loop. In other words, it constitutes an alternative to the traditional educational model, which is based on the relationship between the person who provides training and the one who receives it, with the former knowing the truth and the latter receiving it. Knowledge dialogues generate an enriching experience for both sides, who all share and learn from their differences. However, these processes are not free of conflict; however, when this arises, it can be resolved by listening to each other, seeking harmony and synergy.

Knowledge dialogues require a *horizontal exchange* to foster a democratic, intercultural flow between the parties in these spaces. Dialogues cannot work if there is mistrust or prejudice. It takes openness to listen and understand, which can only be achieved between equals. *Mutual respect and transparency* are crucial.

Knowledge dialogues also represent a more developed form of *community participation*, since it is based on an agreement between the participants, who are all on equal terms. The agreements arising from these dialogues are accepted by both sides; health services, other people, and the community become co-responsible, in a form of community co-management.

Using this dialogue technique makes it possible to improve access to services (including health services) by populations in situations of high socioeconomic vulnerability, who do not have access to these services for different reasons: lack of knowledge, lack of culturally appropriate services, anticipation of mistreatment by health workers, not being able to express themselves in their own language, and different cultural practices regarding illness and health, among others.

Knowledge dialogues have an educational and communicational dimension, but also aspects of planning, with joint actions involving communities and services so that results can be obtained within a defined process and schedule. The very fact that a dialogue is held represents an accomplishment, because of the interaction between the group concerned (for example, an indigenous population) and health staff. Consequently, a series of agreements can be reached to achieve short-, medium-, and long-term results, leading to real social change.



1.2

WHAT IS THE PURPOSE OF KNOWLEDGE DIALOGUES?

Knowledge dialogues (or intercultural dialogues) make it possible to understand and resolve specific problems of diverse population groups, such as indigenous or Afro-descendant people. If they are implemented with a methodology adjusted to the realities and contexts on the ground, thus enabling greater participation by countries and communities, they can be a key tool for achieving the 2030 Agenda for Sustainable Development and the commitment to leave no one behind.

The Policy on Ethnicity and Health, approved unanimously in 2017 by all PAHO Member States, recognizes that indigenous peoples, Afro-descendants, and Roma (among other groups) often face discrimination and exclusion, leading to inequities in health. Likewise, in the Region of the Americas, the Strategy for Universal Access to Health and Universal Health Coverage, approved by PAHO Member States in 2014, establishes similar commitments to ensure that all peoples and communities have access, without discrimination, to comprehensive, adequate, timely, quality, health services. Achieving these goals for indigenous peoples and other groups demands new ideas and working methods.

In this context, knowledge dialogues have the following specific purposes:

- > **Analyzing, exploring, and solving problems.** Through analyzing and discussing problems, solutions can be found. Knowledge dialogues untangle complex situations and are key to achieving results to improve health. In this process, all social actors are essential, by virtue of their contribution to the common task of building health.
- > **Communicating and informing.** Knowledge dialogues are a powerful tool for enabling everyone to communicate, get to know one another, and consider the feelings and perceptions of others, as well as their expectations.
- > **Learning.** Through knowledge dialogues, participants learn to find the roots and effects of each side's problems or priorities. For example, a dialogue can reveal how both parties view medicine, and the sense of complementarity of both kinds of medicine: traditional and Western.
- > **Cooperating.** Knowledge dialogues have an impact on promoting cooperation between the parties. Dialogue fosters tolerance and respect—necessary conditions for harmonizing efforts collaboratively. Dialogue shortens distances and encourage synergies.
- > **Reaching agreements and taking action.** Knowledge dialogues result in actions and commitments so that both parties can work together to solve their problems and address the priorities identified.



1.3

PARTICIPANTS IN DIALOGUES

Knowledge dialogues are conducted with culturally diverse groups of people. While this guide focuses on ethnic groups, the instrument can be applied to any population group, as well as to other sectors and areas (not only those related to health). An example would be health professionals and other workers in the health sector engaging in a dialogue with citizens who are indigenous, Afro-descendant, or belong to other groups. Based on mutual recognition and collaboration, the actors involved seek to understand the problems in their territory, proposing alternatives for improvement that require the participation of all members of the community, resulting in mutual learning throughout the process.

In the case of a participatory local planning workshop, it is important to involve the leaders of grassroots or communal social organizations, which constitute the core of the social fabric of the community or district. These include, for example, communal development committees and religious, educational, cultural, or youth organizations (among many others), according to the problems to be addressed. The participation of other social actors from outside the health sector will depend on the issues that need to be analyzed. For example, if during a dialogue it has been agreed to address the problem of unsafe drinking water, all sectors related to water distribution, quality control, and consumption should be involved, in addition to the health sector.

Depending on the issues to be considered for the development of a work plan, participating sectors may include education, development and social inclusion, housing, human rights, building and sanitation, agriculture, security, and environmental issues.

1.4

HEALTH MANAGEMENT PROCESSES AND KNOWLEDGE DIALOGUES

To manage PHC-based health models, it is essential to understand how intercultural dialogues can become a methodological tool that works in coordination with operational processes aimed at improving health access and coverage.

In these situations, knowledge dialogues should be considered as part of broader processes, which are carried out in the spaces of daily life and in the settings created by health institutions. The work of creating a knowledge dialogue is conducted on a day-to-day basis, both in the different areas of ethnic communities' everyday lives, and in the spaces where health services do their usual work. Also, on a scheduled basis, these dialogues are used by institutions from different sectors to forge agreements with the leaders of diverse communities.

For example, in contexts where indigenous or Afro-descendant communities live, knowledge dialogues can strengthen intercultural relations through family visits, generating ideas and plans that impact the social determinants of health, and through the creation of effective, binding mechanisms for the relationship between health institutions and ancestral health systems.

1.5

POTENTIAL SITUATIONS FOR APPLYING KNOWLEDGE DIALOGUES

There are two types of knowledge dialogue, conducted in two different situations (table 1). The first encompasses short educational sessions to share information and knowledge about certain problems (for example, in this case, involving health). The main problem must have been identified previously by both groups. The second type relates to participatory planning with communal authorities, the indigenous population (or the group in question), leaders, health workers (or from other sectors), and other key actors. The objective in this second situation is to plan actions and delve deeper to offer joint solutions to a certain issue. In both situations, the methodology is similar: analysis of the problem, causes, consequences, planning, and actions.

Table 1. Situations for applying the knowledge dialogue methodology**AS AN EDUCATIONAL TOOL**

- The problem identified is analyzed in brief interpersonal, teaching/learning educational sessions, in which the participants present their opinions.
- Once the problem is defined, questions are posed to the convened group (for example, groups of mothers or community actors), enabling the participants to show their knowledge about the problem and to understand what others know (such as health staff).
- The role of the facilitator is eminently educational, and from the outset this person's objective will be to assess the prior knowledge of those involved (e.g., How? and Why?).
- As participants learn more and find causes, they become able to propose their own actions based on the perceptions and practices of both parties; for example, a particular indigenous community and the health service.

AS A PLANNING TOOL

- This is a participatory planning workshop in the form of a dialogue, which marks the beginning of a process that should continue over time, to observe the results and relevance of its application.
- Depending on the problem that it was previously agreed to address, participants should include representatives from communities, government agencies, and organizations that have an impact on the issues to be analyzed.
- This methodological sequence enables working groups, a plenary meeting, and debate.
- The role of the facilitator is to empower participants to conclude with a series of actions ("intercultural minimums") for the population and the sectors involved. These actions will constitute the work plan.
- This work plan should be monitored, and subsequent meetings and dialogues should constitute a form of accountability (among all the participants) and provide continuity to the process.



A) WHO ORGANIZES KNOWLEDGE DIALOGUES?

Knowledge dialogues should always be convened through a *partnership or group promoting the initiative*. This group should comprise the two parties that will meet during the dialogue sessions (e.g., health services and the local indigenous organization involved). Together, they constitute the organizing group, which assumes responsibility for the process, agreements, and follow-up. It should be stressed here that for the dialogue initiative to take place, both sides must agree on the problem.

Dialogues can only move forward to the extent that there is a prior agreement between the institutions and the population group concerned (for example, the health sector and an indigenous community, or the human rights sector and a group of migrants).

Dialogues are requested or conducted in a context in which there is already a pre-existing dynamic between the community and the institutions, within which problems have arisen that, for whatever reason, cannot be resolved. For example, it may be an indigenous area with a high incidence of COVID-19, where community members need evidence that the disease really exists because it is something they cannot see, and when symptoms appear, they are attributed to other causes derived from members' own perceptions. Therefore, in these dialogues it is necessary to determine how people understand the issue involved, and to see whether alternatives should be sought to enable their full understanding. To do this, cultural and knowledge mediation will be necessary, working with the communities as subjects of law and subjects of knowledge, and not as research subjects.



B) FACILITATORS OF INTERCULTURAL OR KNOWLEDGE DIALOGUES

Of particular importance is the figure of the dialogue facilitator. This person could be recruited from health staff or the participating population group (e.g., indigenous population or migrants), for example, a member of the community who has been trained in using the knowledge dialogue methodology, and who is versed in the local traditional culture.

Ideally, dual coordination would be established, with one facilitator from the institutional side (health sector) and another belonging to the group, people, community, or population that will participate in the dialogue process. If this kind of dual coordination is not possible, then a person from only one of the parties should be designated. The facilitator from the institutional side (in this case, the health sector) must have specific competences, such as cultural and linguistic translation skills, and must be able to deal with the possible tensions that may arise (for example, between health services and communities). Moreover, they should be sensitive to gender issues. Other crucial characteristics are impartiality, objectivity, respect, and—above all—knowledge of the situation being addressed.

To learn more about the facilitator's role, consult *The Knowledge Dialogue Methodology: Manual for Facilitators*, available online here: <https://www.paho.org/es/documentos/metodologia-dialogos-saberes-manual-para-facilitadores-0>

1.6

WHAT PROBLEMS ARE ADDRESSED IN KNOWLEDGE DIALOGUES?

In these spaces, problems or priorities that affect the participating population group are addressed. First, it should be emphasized that the health problem or priorities to be addressed must be agreed in advance between the two parties. This means that it is a concern for both parties, and not just for one of them. Without this consensus, it will not be possible to conduct the dialogues.

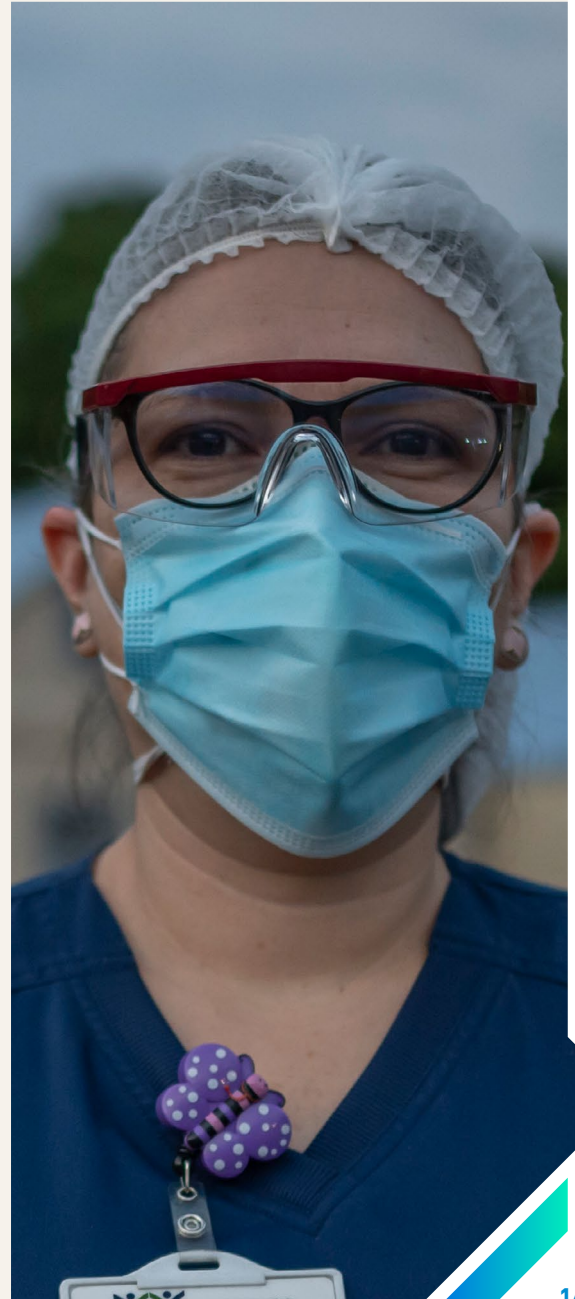
As already indicated, for the dialogue process to be effective, the participants in the meeting must have prior knowledge of the subject to be discussed. For example, if health workers consider HIV/AIDS to be a problem in a particular community, but for members of that community it is not a problem, then a dialogue cannot take place. However, through awareness-raising and advocacy efforts by health staff, leaders or interlocutors in the community or group in question can learn more about the problem of HIV/AIDS, making it possible to hold a dialogue later.

It is also necessary to take into account the relevance of the problem, as well as the feasibility of its solution or improvement. Simply holding a dialogue does not end a problem; knowledge dialogues must be considered part of an ongoing process that contains several significant phases or meetings. That is why we talk about *dialogues*, in plural.

As a result of the knowledge dialogue process, and the implementation and monitoring of the resulting agreements, there should be a change in the problems initially identified. The purpose of knowledge dialogues is to generate intercultural approaches, which can be reflected, for example, in a series of modifications in the health services and healthy practices of the populations involved (e.g., indigenous peoples or Afro-descendants). This can be manifested in the following ways, among many others: the cultural adaptation of health services for the indigenous population (or another population group); incorporating alternative medicines; improving the treatment and hospitality extended to the Afro-descendant population or migrants (or other); changing the ways of communicating symptoms or accepting treatments; and promoting research in local traditional medicine.

With regard to the participating populations, within a given time horizon, some of the following changes could also be expected as a result of knowledge dialogues: full knowledge of their rights; a more day-to-day dialogue with health staff and other sectors; perception of the need for health care; knowledge of activities beneficial to their health, such as prenatal care, vaccination, good nutrition, or the use of drugs from Western medicine to combat certain diseases; and the importance and usefulness of obtaining a national identity card for newborns as a recognition of their rights.

Past experience with knowledge dialogues indicates that together, the parties construct “intercultural health minimums”, or “intercultural minimums”; i.e., health milestones that are fully agreed upon in the dialogues.



Intercultural minimums are a condition for both cultures, commonalities on which both sides agree. In an educational session, these minimums constitute the messages; in other words, the knowledge shared between both parties about the roots of the problems and their solutions. On the other hand, in a participatory planning workshop, these minimums constitute the work plan—usually short- or medium-term—in which actions are defined involving the indigenous or other community, the health sector, and other social actors who have participated. These actions should be monitored to jointly evaluate whether or not change occurred.





2

HOW TO CONDUCT
A KNOWLEDGE DIALOGUE

There are three essential, well-defined phases in a knowledge dialogue (table 2): the first, *creation of conditions*; the second, *interaction between the parties involved*, or the dialogue session itself; and the third, *implementation and monitoring of the agreements*.

Description of the phases in a knowledge dialogue process

A. CREATION OF CONDITIONS (IN THIS CASE, HEALTH SECTOR)

- Positioning and deciding on the person who will be in charge of the service network or setting up joint leadership with the group in question (these decisions are always agreed between both parties).
- Forming an institutional team that will work with the group in question (e.g., indigenous people, Afro-descendants, migrants).
- Awareness-raising and information on culture, multiculturalism, and intercultural health provided to all health staff.
- Identification of facilitators, knowledge dialogues, and training (these efforts will be shared and agreed with the group in question).
- Description of the problems that affect the population involved and the existing gaps (which will have been defined and agreed previously in coordination with the population group in question).
- Identification of community leaders (indigenous or other) and preparatory meetings to explain whether an educational meeting or a participatory planning workshop will be held. This also requires a prior trust-building process.

2-3 MONTHS OF INTERNAL PROCESS

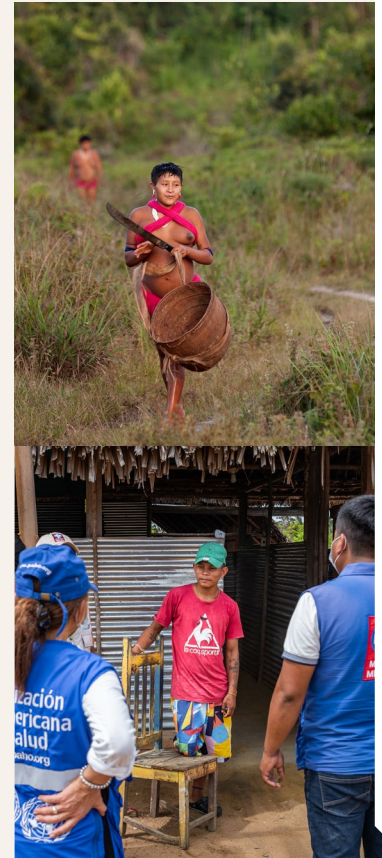
Description of the phases in a knowledge dialogue process (cont.)

B. MEETING-DIALOGUE-INTERACTION

- Using the agreed problem as a starting point to conduct an educational meeting or as an input for the planning workshop.
- Analysis of causes and consequences of the problem: acknowledgement and sharing of institutional knowledge and knowledge of the participating population, their perceptions about the roots and effects of the problem.
- Horizontal interaction and learning, involving everyone and for everyone.
- Prioritization of the causes: those that constitute a starting point and those closely linked to the root of the problem.
- Agreement on actions to be taken (final part): What do we do? How? With what? When? With whom? Set of questions for each prioritized cause.
- The actions correspond to a work plan agreed between the health staff and participating population (indigenous, Afro-descendant, or other).
- Determining the date of the next knowledge dialogue meeting to share the actions developed under the work plan.

EDUCATIONAL MEETING: 2 HOURS

PLANNING MEETING: 6 HOURS



Description of the phases in a knowledge dialogue process (cont.)

C. IMPLEMENTATION AND MONITORING

- Analyzing and prioritizing the work plan agreed at the meeting: leaders, teams, training, etc.
- Determining the work plan as a responsibility of the team established (which includes a specific sector, as well as a defined population group).
- Designing activities to improve opportunities or intercultural competences, in accordance with the work plan.
- Programming the next knowledge dialogue meeting: its purpose will be horizontal accountability regarding progress on the planned activities.
- Monitoring every 3 months to see whether activities are solving the problem or problems identified by both parties, or if they need to be reviewed.

IMPLEMENTATION: 3–6 MONTHS TO 1 YEAR

LINKAGE WITH OTHER PROBLEMS: 6 MORE MONTHS





2.1

PHASE ONE: CREATING CONDITIONS (VIA THE HEALTH SECTOR OR ANOTHER INSTITUTIONAL SECTOR)

A) POSITIONING KNOWLEDGE DIALOGUE LEADERS

As already noted, health-related knowledge dialogues form part of an intercultural health approach that begins under the shared responsibility of several sectors; for example, the health sector and the members of a certain population group. The first thing that must be achieved is a common feeling about the problem involving both parties: in this case, the health sector and the community or population group concerned.



An explicit decision regarding who will be the person coordinating or in charge from the health sector is crucial, because the health services will have to make a series of qualitative changes—which will have to be promoted, precisely, by the people in charge of the coordination or leadership of these health services. Some countries have national plans for indigenous health or intercultural health, thus facilitating this process of taking on such a guidance role. On the contrary, if there are no explicit policies in place, and there are indigenous populations or other affected communities in the country, the decisions and attitudes of authorities at the subnational and local levels play an essential role. Moreover, this is a shared responsibility, because for the dialogues to take place under conditions of equality, there must be a prior agreement with the population group that has the problem in question.



B) FORMING AN INSTITUTIONAL TEAM TO WORK WITH THE AFFECTED GROUP IN CONDUCTING KNOWLEDGE DIALOGUES

In the case of a health-related issue, the team will comprise representatives from health services, health promotion, and community work, as well as the person in charge of the specific issue (indigenous or other), supported by the coordinator or the person in charge of the local health services. The people responsible for training and communication will also participate. This team should be knowledgeable or trained in general aspects of intercultural health and gender issues. In addition, it must include a person who will facilitate the dialogues from an institutional perspective. The team's objective and its commitment are to prepare the conditions for knowledge dialogues and to monitor the resulting agreements. All this must be done through consensus, in coordination with the affected group (indigenous population or other).

C) ROLE OF THE HEALTH SECTOR'S INSTITUTIONAL TEAM

The institutional health team will work in a coordinated manner and agree on the basics with key representatives of the population group that has the problem. On the basis of these basic elements, this team should:

- i) Provide awareness-raising and information on key cultural elements, multiculturalism, and intercultural health to all health staff involved. Therefore, cultural relevance and changes in health services must be part of a conscious process involving aware, informed people.
- ii) Identify, or assist in identifying, facilitators for the knowledge dialogues. It is essential to have a person who has good communication skills, experience in community work, and—especially—is a keen listener. This person will be appointed by common agreement between both parties (health sector and key representatives of the group in question).
- iii) Describe the health problems affecting the population concerned, and the existing gaps. The institutional team should call upon the expertise of different services and specialized areas, such as epidemiology or community work, to analyze the intercultural health situation, clearly detailing the health problem or problems that—as the parties have established by common agreement—are affecting the population or group in question. It is essential to stress here that both parties must have previously agreed on the problem(s) to be addressed.



- iv) Identify key leaders (from indigenous, Afro-descendant, or other communities) and hold preparatory meetings for the agreed knowledge dialogue sessions. The institutional team should be knowledgeable about the social and organizational architecture of the population in question, including positions and functions. It should have the capacity to advocate, influence, and hold preparatory meetings to agree on aspects of health care, detect health problems that need to be analyzed, and present the proposed solutions. Also, to have a work plan, the date, place, and time for holding the knowledge dialogues will be agreed by consensus.
- v) Talk with the representatives of the affected group (indigenous or other) and agree on the problems that will be addressed as well as the dates, participatory dynamics, and materials that will be used to achieve a better understanding of the issue. It is advisable to use a variety of techniques. Among other elements, the following are recommended: graphics, oral narratives or stories about the community's experiences, diagrams, and testimonials. The cultural and linguistic adaptation of these materials and tools should also be considered.



2.2

PHASE TWO: CULTURAL INTERACTION

The knowledge dialogue session itself is the cultural interaction phase. This is when the actors meet, the time when all participants can present and share their experiences and ways of thinking. During this phase, the intercultural minimums referred to earlier are constructed.

The entire interaction or session comprises three sections:

- a) Presentation of the knowledge dialogues.
- b) Debate on the problem: its causes, consequences, and actions to be taken.
- c) Work plan of the joint intervention.

According to the criteria of the people in charge of organizing the dialogues and the facilitators, the sequence should occur as follows:

Methodological explanation → Group work →
Plenary for group agreements and debate → Conclusions.



A) PRESENTATION OF THE DIALOGUE SESSION

At the beginning of the session, the facilitators should identify themselves, thank the participants for their attendance, and welcome them. After the individual presentations, *the central theme of the dialogues should be introduced*, including its context, objectives, and methodology. This is the time to inform and communicate; although it does not have a set duration, it should not take up all the time of the entire event. This is an important moment, because it is the first face-to-face meeting in the knowledge dialogue process. Therefore, it should be in the form of a conversation with the participants, who may have some questions about how the session is going to be run, and how agreements will be reached.

At this time, the ground rules of the dialogues should be established participatively: among many others, they should include a guarantee of mutual respect, free participation, equality among the participants, non-aggression, management of disputes, respect for allotted times, and punctuality. This list of rules is crucial for the group and must be respected as the sessions are conducted.

After this stage, the workshop proper will be held. Its structure may vary, but in general it is advisable to focus on four subtopics: the problem, its causes, its consequences, and the actions to be taken.



B) DEBATE ABOUT THE PROBLEM, ITS CAUSES, AND ITS CONSEQUENCES

The facilitator will present the problem to be addressed. They will also briefly explain, with examples, how to identify the causes of a problem, its consequences, and actions to solve it. At the end of this presentation, the facilitator will leave some questions to be answered by the other participants.

The causes of the problem can be found by asking questions such as: Why is there a problem? Why does cause 1 happen? Where does cause 2 come from? What made cause 3 happen? This exchange can continue until multiple answers are found. Next, sort the causes into similar groups, which should lead to a tree diagram, from which consequences can be drawn.





As the methodology for knowledge dialogues differs substantially from that of the classic model of seminars or academic events, it is advisable for the facilitator to encourage the social actors to take another kind of methodological approach, which includes some of these criteria from past experiences:

- i) It is possible and advisable to *motivate others with real-life experiences*. It is best to use cases that are interesting to the participants. Concepts flow out of lived experience, contrary to what traditional education indicates. Understanding of the problem should be facilitated through a story that everyone knows, from some popular saying in the community, or some image from their environment.
- ii) *Express the experience first*, to then turn it into a narrative and a concept. Promote the emergence of experiences. Support statements with emotions, knowledge, and feelings related to the problem being discussed. Use the appropriate methods for participants to analyze what is happening, and why, on their own terms.
- iii) Know how to *share knowledge*, which must be based on the life of the community. The challenge is for people to take on board what they have learned, and for there to be a sense of change in the participants, in addition to mutual learning.
- iv) Throughout the entire session, the differences that can arise because of gender issues should be borne in mind.

After the initial explanation, the next step is to select the working groups according to criteria established by the participants themselves. The optimal number of participants should be sought for a good debate, and for orderly work to be carried out. The facilitator will announce the approximate available time for the task. Each group will appoint the people who will serve as their facilitators and rapporteurs. The rapporteur will take note of the opinions and agreements. The facilitator or other member of the group will present the agreements at the plenary meeting. The group's conclusions will be written on flipcharts or another form of visible media for the people participating in the plenary.

The facilitator may use diagrams or other appropriate means to present the causes of the problem in an educational manner. These diagrams can be given to the working groups, to be filled in during the debate on the problem and its root causes. During this exchange, the first thing to be done is to collect all the opinions on the causes, and then sort them into groups, with a short title summarizing each set of causes. These titles will reflect the direct causes, and below them will be listed the multiple indirect causes related to the central or direct causes.

The basic planning methodology has three steps, which are summarized in the figure below.

Stages of the basic planning methodology



C) IDENTIFICATION OF THE ACTIONS TO BE UNDERTAKEN: THE WORK PLAN

This is the last part of the participatory planning workshop. As in the debate about the problem, its causes, and its consequences, the dynamic of working groups will be used. This is a matter of answering such questions as the following: What do we do? How do we do it? With what do we do it? With whom? When?

This set of questions applies to a single cause. That is, when causes are prioritized (for example, three root causes are set out), actions relevant to each cause should emerge from the answers to this set of questions. Therefore, this step reflects what the participants are doing and are able to do. The work plan can even conclude by determining dates for upcoming meetings and the frequency of monitoring.

If the causes of the problem are clear, the solutions presented should be equally clear. Solutions will probably need to be prioritized. At this time, the groups sort through the set of existing opinions and select the solutions with the greatest potential impact that they consider to be the most viable and achievable. The same process will then be repeated at the plenary meeting.

The work plan should involve all interested actors and groups; it should be not only a technical tool, but also a social one.

Precise programming or scheduling of activities is recommended, with estimated deadlines for each one (table 2). To do this, it is essential to have an idea of how the processes and activities fit together, to know where to start and where to end. The workshop should conclude this phase with an agreement among all the participants.



Table 2. Work plan proposal

OBJECTIVES	The desired end point(s).				
GOALS	What participants hope to achieve through a procedure and certain actions.				
ACTIVITIES	Specific actions to be carried out.				
PERSONS RESPONSIBLE	People in charge of carrying out the activities.				
EXPECTED OUTCOME	Effect or consequence of implementing the activities and actions.				
TIMELINES	MONTH 1				
	Activity	Week 1	Week 2	Week 3	Week 4
	Example 1				
	Example 2				
	Example 3				
Example 4					



2.3

PHASE THREE: IMPLEMENTATION, SUPERVISION, AND MONITORING

The team that organizes, orients, and directs the implementation of the agreements will have two essential responsibilities: a) providing management guidance (the team does not act directly, but through those responsible for each line of activities), and b) supervising, monitoring, and evaluating the implementation of the agreements. Both tasks are described below.

A) MANAGEMENT GUIDANCE

In this area, the team should carry out the following functions:

- i) **Stay focused on the objectives.** It is very important that as the work plan is carried out, the actors stay *focused on achieving the objectives and goals*. The intervention has a central objective, and this is condensed into the main goal. Within the framework of each general objective, there are also specific objectives, and each one has its own specific lines of activities and actions. The deliverables are activities or outputs to be organized over the next three months, and which bring the committed population closer to the established goal (in this case, health). Staying focused makes it possible to center attention on implementing the program, to avoid getting distracted by other activities.



- ii) **Manage time.** When designing the work plan, a number of activities and outputs are formulated and approved. In addition, the duration of each task and the resources for carrying it out are defined, and a timeline is drawn up. During this phase, the coordinating team should compare the times set forth in the plan with the execution deadlines, to devise improvements. Likewise, the coordinating team will verify whether the lines of activities and actions are completed within the defined deadlines.
- iii) **Manage quality.** Both the quality of the dialogue process and the quality of its resulting products or activities will be monitored. To do this, it is important to talk with the teams implementing each activity or output in order to identify the factors that can cause poor quality of the process or product and, consequently, to make improvements, following a plan → do → review → act sequence. Quality supervision and monitoring involve dedication and effort; however, mistakes mean much more work, and the loss of trust can be irreparable. An agreement can meet the scheduled deadlines, but with low-quality results.



- iv) **Manage communication and relations with the population and institutions.** A multicultural intervention will always have the potential weak spot of poor communication. Agreements may be moving forward, but a delay in communication can lead to discouragement and opposition. The coordinating group must pay special attention to this area of activity. Communication builds trust, and this is essential to achieving goals. Communication will not necessarily be on a massive scale: it can (and should) also be interpersonal. Effective communication builds a bridge between the different people involved.

It is important for there to be transparent action that encourages accountability and shared responsibility among the actors involved. Therefore, permanent lines of communication must be established between all the people involved in the knowledge dialogues, through their key representatives. If the agreement is not met, the actors must know this, and they must also know the reasons for delays in meeting the deadlines.



- v) **Manage costs.** Knowledge dialogues are invaluable, but they come at a cost. Simply by carrying them out, the population concerned incurs an enormous out-of-pocket expense, while also investing their time to achieve more and better health. The coordination group must be aware of the costs of each activity and outcome, to make the most of voluntary resources and health services and community resources, as well as to ensure viability.

B) SUPERVISION, MONITORING, AND EVALUATION

The success of a knowledge dialogue rests on systematic follow-up of the implementation of its agreements and actions. First, it is important to differentiate between supervision, monitoring, and evaluation. Supervision should be face-to-face and carried out in the field, while monitoring can be done remotely and in an ongoing manner. There should also be regular evaluations, seeking a causal link between what is done and the effects or results.

In this case, the key is to monitor the agreements decided upon. A brief monitoring report should be produced each month and per quarter or semester, as well as an evaluation. This will enable evaluators to make recommendations to the coordinating team and to detect errors or shortcomings early on. It should be emphasized that monitoring the commitments made is not synonymous with pronouncing judgement, but with understanding and support.

After a few months, it is important to revisit the original plan with a sequence of dialogues that extends over time, so that all the actors can review the agreements, re-examine the deadlines, and make adjustments. Community involvement is vital for monitoring progress; therefore, the knowledge dialogue sessions must have continuity over time.

The background features a blurred architectural scene with a series of parallel, curved lines, possibly representing a modern building's interior or a series of steps. The colors are a mix of warm yellows and oranges, and cool blues and purples. Overlaid on this are several large, semi-transparent geometric shapes in shades of blue, teal, and purple, creating a dynamic, layered effect.

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Knowledge dialogues, also called intercultural dialogues, are a process of communication and exchange between people, groups, or communities from different backgrounds or cultures. In the case of the health sector, these exchanges take place between certain groups or individuals and trained health staff. The objective is, among others, to improve access to health services and to build intercultural health, with an emphasis on solving previously defined problems and their causes, mutual understanding, and forging solid ties.

This publication presents the methodology applicable in this field. It is aimed at workers in the health field, as well as other areas and sectors, to further their efforts to find ways to learn, share, and build healthy practices. Although indigenous, Roma, and Afro-descendant populations are considered here, the methodology can be applied to working with any group, such as migrants, displaced persons, adolescents, or older people, who have problems with universal access to health and universal health coverage.

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