World Vision

Facilitator's Manual for Community Health Committees (COMM)

Session 3a: Root-Cause Analysis (Light Version)

Identifying Health Issues for Action with the Community

Field Test Version

Published by Global Health on behalf of World Vision International.

For further information about this publication or World Vision International publications, or for additional copies of this publication, please contact wvi_publishing@wvi.org.

Authors: Michele Gaudrault and Elaine Franklin (consultant). Contributors: Erin Jones, Armen Martiroysen, Anna Paden, Lianna Sarkisian and Teresa Wallace. Publishing Coordination: Katie Fike. Content Editor: Marina Mafani. Copyediting: Joan Laflamme. Proofreading: Anna Claire Okeke.

Cover photo © Paul Bettings/World Vision
Cover photo: Nean Chou (far left) and Onn Kom (far right) are health workers who are part of the Village Health Support Group, organised by World Vision, in Cambodia. Nean and Onn visit pregnant mothers within their community, advising how to properly care for their babies.

CONTENTS

SESSION 3a: Identifying Health Issues for Action with the Community

(Session 3a Contents continued)

Toolkit

SESSION 3A: IDENTIFYING HEALTH ISSUES FOR ACTION WITH THE COMMUNITY

Notes for the Facilitator

In this part of the COMM's work, priority health issues will be identified and selected for community-level action. It is important that the identification of key health issues is not limited to the ideas of the COMM alone, but rather, that the COMM involves the wider community. The recommended steps are summarised here.

Step 1: Prepare the COMM for Community Consultation

In this step, the COMM members will look at national and local-level health indicators, and then as a group discuss what they feel the most important health issues are in the community. They will undertake a 'why-why' analysis (explained in activity 4) to understand some of the root causes of the problems, and identify assets or enablers that can help to address those causes. If the issues identified relate to the 7-11 health practices, you will provide the group with related information to assist in the analysis.

It is important to understand, however, that the issues that the COMM prioritises and the root causes it identifies may not be the same as those that would be voiced by the more vulnerable or marginalised members of the community. You will help the COMM to consider this, and to consider ways of ensuring that the concerns of the more vulnerable do indeed surface and can be addressed.

Step 2: Create an Action Plan and Use it to Monitor Progress

Once the COMM knows the steps it needs to take to identify and prioritise health issues with the community, it will create an action plan for carrying out the next steps.

Step 3: Community Workshops to Gather Information and Views

The COMM will then gather information from community members themselves, regarding their perceptions of the most important health issues and their identification of the root causes of the issues. A workshop can be held for this purpose, with approximately 30 selected community members. It will be important to ensure that the more vulnerable are included, which may necessitate a separate workshop with them.

Step 4: Health Facility Interview

The COMM will also interview the local health facility to learn about existing health services.

Step 5: Analysing and Preparing the Information

The COMM will review all of the information it has gathered and prepare to present it at the community meeting.

Step 6: Community Debriefing and Planning Meeting

Finally, the COMM will organise a community-wide meeting to present the results of the preceding steps, validate or modify the results, and agree together on ways of addressing the priority issues.

Alternative: If time and resources are limited, it may be possible to skip steps 3, 4 and 5 and limit the community involvement to step 6 only; whereby the COMM and the community members gather all information, analyse it, and create an action plan in one inclusive community meeting. This is less ideal than the recommended six-step process and if the COMM decides to do this, it will need to find ways to ensure that the voices of the most vulnerable are heard in the community-wide meeting.

STEP 1: PREPARE THE COMM FOR COMMUNITY CONSULTATION

Facilitator Preparation for Step 1

Obtain Data and Prepare the Visuals

Prepare for this activity by obtaining data for your country and preparing the flipcharts for the training.

Key Health and Nutrition Concerns (Tool 3a-1)

Make a copy of Tool 3a-1, Key Health and Nutrition Concerns. You will need to collect the information for most of the indicators on this form for your country. You will see that there are columns for national-level data and for local-level data, if they are available. You may need to work with your supervisor to do this, or perhaps your supervisor already has the information.

You will see that Tool 3a-1 gives ranges for each of the indicators and codes them as green, yellow or red, with red being the most critical. Notice also that the ranges are different for every indicator. This makes sense if you think about it. We want to see low numbers of children dying, but high numbers of immunisations, for example. Each indicator is different, and each has its own range. These are internationally accepted ranges indicating the seriousness of a situation. When you have filled in the figure for an indicator, look to see if it falls in the green, yellow or red range. This will help you to see which indicators are the most difficult in your country (red).

Now prepare a flipchart. You should present most of the indicators to the participants. Write the indicators (or an easy abbreviation) neatly on the left. In the first column write the number that begins the critical (red) range. You will explain to your group that anything worse than that statistic is considered critical. Then write the actual statistics for your country; include both national and local data if you have them. Then, be sure to cover up the last two columns. When it comes time to present to the group, show the critical (red) statistics and then ask the participants if they think the statistics for their country are better or worse.

An example for how to prepare your flipchart is shown below. The example shows two indicators in the first column. As shown in Tool 3a-1, the red limit for maternal mortality is 300 per 100,000. For stunting, the red figure is 30 per cent of all children. Anything above that is critical. Remember, you will cover up the last two columns so that the participants can guess if they think it is red, yellow or green in their country. After they guess, you can display the numbers. In this example, maternal mortality is critical at both the national and the local levels; the numbers are much higher than 300. For stunting, the situation is below critical at the national level, with 19 per cent of all children stunted (green). However, it is critical in the local area.

	Critical	National	Local
Maternal Mortality	300	550	530
Stunting	30%	19%	31%

Now you are ready to present to the group.

Note on Contextualisation

If you are working with a COMM that focuses on areas other than maternal, newborn and child health (MNCH) – a COMM perhaps working with adolescents or adult men's health for example – then you will need to add to or replace Tool 3a-1, to include indicators relevant to the health issues the COMM is concerned with.

Activity 1: Determine What the Group Members Already Know

Ask the COMM members what they think are some of the most important health issues in the community. Listen to their answers. Explain that, together as a group, you will go into these issues in more depth during this session.

Activity 2: Setting the Context with Basic Maternal and Child Health Indicators

Post the prepared flipchart pages with the indicators for discussion on what is happening in the country. Remember to cover the last two columns. Show the first indicator, and point to the red statistic that you found on Tool 3a-1. Explain that this number is the cut-off for critical; anything worse than this number for this indicator represents a critical situation. Ask the COMM members to guess if they think the situation in their country (national level) and area (local level) is better or worse than the statistic shown. Then uncover the answers for that indicator in the two right columns.

Allow time for the group members to think about and discuss what is happening in their community and how this corresponds to the national situation. What health issues are the most serious nationally? What health issues are the most serious in their community?

Activity 3: Our Priorities

Now the group members should decide what health issues, for them, are the ones they are most concerned about; either because they are personally affected or because they feel strongly about the issues' importance to the community. The group should prioritise between three to five important health issues. These do not necessarily have to be related to the issues presented in Activity 2; rather, the COMM should think in a completely open-ended way about important health issues in general.

Activity 4: Ideas About the Root Causes of the Prioritised Issues[1]

For this activity you will lead the group to create a 'Bubble Map'. In essence, this means that for each health issue, the group will ask the question 'why?' and 'why?' again. Explain as follows:

- Decide which of the health problems to begin with. Draw a square in the middle of a flipchart paper and write the name of the health problem in the middle.
- Ask, 'What do most people in the community think are the reasons for this health problem?' As participants answer, they will write all the answers in circles and draw a line connecting each circle to the middle square.
- Once all the first answers have been written, then ask, 'But why?' for each answer. This will lead the participants to find out how things are connected. They will write the new answers in circles and connect them to the other answers with a line. Keep asking 'Why?' until there are no more answers.
- Repeat this process with the other health problems; each on separate sheets of flipchart paper.

This helps the group members to understand the root causes of the problems they have identified. What is behind, or at the bottom of, each problem? Asking 'why, why' helps to uncover this. They should save the papers for later.

Activity 4a: If Relevant, Supplement with Select 7-11 Health practices

Depending on the issues that the group has prioritised, you can review the underlying health practices that may be contributing to the issue, using the list in Tool 3a-2. For example, if malaria is prioritised, review the behavioural practices listed under the malaria category; both for pregnant women and for children. If the participants do not have complete knowledge of the subject, use the *Facilitator's Guide to 7-11 Health Information* and carry out a mini session.

Explain that the failure to carry out these health practices may be contributing to the problem, and the group can add this to its analysis. Guide the participants as follows:

- Make five columns on flipchart paper. In the first column, list the 7-11 practices related to the identified health issues.

[1] Adapted from *Simplified Guide to Community Health Planning: Facilitator's Manual 2013.* Ministry of Community Development Mother and Child Health, The Government of the Republic of Zambia.

- Participants self-assess: for each of the health practices, do they personally (or their spouses or family members) practice the behaviour? Each participant puts a tick in the second column if so.
- To the best of their knowledge, do community members in general practice the behaviours? If so, tick the third column.
- For those behaviours not practiced, what are the reasons why not? What makes it difficult to practice these behaviours, both for themselves and for other community members? These are 'barriers'. Write the barriers in the fourth column.
- For those behaviours not practiced, what sorts of things would make it easier to practice them? These are 'enablers'. Write the enablers in the fifth column. Save the flipchart paper(s) for later.

Activity 5: Consider Birth Registration

The COMM members and the community will be more motivated to act if the issues they are responding to are issues that they themselves prioritise. It is for this reason that you are asking them what is important to them, rather than trying to guide them towards pre-determined health concerns.

However, one issue that may be worth raising is that of birth registration, as it is probably unlikely to arise spontaneously from the group's own reflections. Birth registration can have a major impact on a child's health and life, and it is an issue that the COMM can play a role in, to raise awareness and motivate action. Mention this to the COMM now and, if the group is open to it, review this section of the *Facilitator's Guide to 7-11 Health Information.* The COMM can decide if it wants to create a Bubble Map for this issue and present it in the community meeting.

Activity 6: Including the Most Vulnerable

Explain to the members that it is very important to understand that the issues that they prioritised, and the root causes or barriers that they identified, may be very different from what more vulnerable members of the community would say. You will take the COMM through a series of activities to consider the perspective of more vulnerable community members, to identify who and where those families are, and to plan for including them in the upcoming community-wide activities. Carry out the following exercises:

- 'How does it feel to be vulnerable' in Tool 3a-3
- 'Who are the vulnerable families in our area' in Tool 3a-4
- 'Where are the most vulnerable' in Tool 3a-5.

Do not skip the first exercise! This exercise is meant for the participants to have a 'felt experience', which is often the first step in opening up to new ideas and attitudes about those one might once have viewed in a negative or indifferent light.

Activity 7: The Health Issues of the Most Vulnerable

Return to Activity 3 where the COMM members identified the health issues that they are most concerned about. This time, they should put themselves in the shoes of the most vulnerable and think about this question again. Do they think that the most vulnerable have the same priority health concerns, or different? If different, what might the top three health concerns be?

Continue with the root-cause analysis; making Bubble Maps for any new health issues; trying to fill in the Bubble Map from the perspective of the most vulnerable.

Then, if the COMM members analysed some of the 7-11 health practices, they should return to those flipcharts. Do they believe that the most vulnerable are practicing these behaviours or not? How do their answers compare with the ticks recorded earlier in columns 2 and 3? Would any of the barriers or enablers be different for more vulnerable community members?

Explain that this activity is not meant to provide concrete information with regard to more vulnerable community members; rather, the COMM will speak directly to some of these individuals in the next step. The activity is meant to ensure that the COMM members are aware of the fact that they cannot assume that the concerns and priorities

of 'general community members' will be the same as those of the most vulnerable, and that it is very important that they hear from these often excluded groups as well.

ACTIVITY 8: IDENTIFYING THE MOST VULNERABLE FOR THE WORKSHOP

In the next step the COMM will organise one or more workshops with community members to gather information, views and opinions. If the COMM feels it is possible to hold one workshop with both 'general' and 'more vulnerable' community members, dividing them into groups, then the COMM can do so. It may be better, however, to work with the more vulnerable separately so that they are at ease and free to express their genuine views.

Discuss this with the COMM members. Will they carry out one joint workshop or two separate ones? How will they identify the most vulnerable, and who among these individuals will they invite? How will they make that selection and how will they explain the work to them? Clarify all of this before ending Step 1.

STEP 2: CREATE AN ACTION PLAN AND USE IT TO MONITOR PROGRESS

Notes for the Facilitator

One of your roles as a facilitator is to collect monitoring information related to your own work and the work of the COMM. The tool you are introducing to the COMM here is the one that will be used to monitor certain indicators related to the programme. The COMM will complete this form for its own use and its own tracking, but you will also ask for a copy each quarter.

You will review this tool for each of the sessions you carry out with the COMM, because the goals (indicators) for each session will be unique.

ACTIVITY 1: INTRODUCE THE ACTION PLANNING TOOL

Provide a copy of Tool 3a-6, COMM Action Planning and Monitoring Tool: Situation Analysis: Identifying Health Issues for Action with the Community (or 'Action Plan') to each COMM member. Review the form, making the following points.

- There is one action planning and monitoring tool for each category of responsibility the COMM has. Each category has one or more goals. Ask the group to read aloud the goal. The goal can also be thought of as a minimum standard or key success factor. Explain that the achievement of these goals can help to ensure the effectiveness of the COMM as a whole.
- The COMM will fill in the activities it will undertake to accomplish this goal. In this case, these activities will include the community workshops, the interview with the health facility, and the community-wide debriefing meeting, along with all of the other preparatory actions needed to accomplish the workshops, meetings and interviews.
- Explain that although the COMM is responsible for this form, you, as a facilitator, are also interested in it. Explain that you would like to receive a copy of the form(s) every quarter (Q1, Q2, Q3, Q4) so that you can also see the progress the COMM is making toward the goals.

ACTIVITY 2: CREATE AN ACTION PLAN AND USE IT TO MONITOR PROGRESS

Draw the first four columns (activity, who, resources and planned date) on flipchart paper. Ask the COMM what it needs to do first, before beginning the community workshops. Does it need to contact community leaders to request permission, for example? If so, include this in the Action Plan. Write two or three proposed activities on the flipchart. In columns next to each one, write who will carry it out, what resources might be needed and the planned date for completion. When you have finished, the group will have produced part of its Action Plan.

The COMM members should now transfer the information from the flipchart onto Tool 3a-6 and then complete the rest of it. The members should decide when they will schedule the workshops, the interview and the community-wide meeting, and what their various responsibilities will be along the way. The secretary of the COMM should complete the table for the activities the COMM will need to carry out in order to complete the 'identification of health issues for action with the community'.

Explain that the COMM will keep track of its progress against these activities using the remaining columns of the form.

STEP 3: COMMUNITY WORKSHOPS TO GATHER INFORMATION AND VIEWS

Notes for the Facilitator

In this step the COMM will gather information, viewpoints and opinions from community members themselves. The best way to do this is to organise one or more workshops with up to 30 community members in each.

The COMM members should ensure that they will be able to speak with and hear from the most vulnerable, as discussed in the previous step. In many cases it will be best to hold a separate workshop with this group.

In the 'general' workshop, the COMM should ensure that a cross-section of other social groups in the community are represented.

Undertake necessary preparation to ensure that the COMM members can successfully facilitate these workshops. The COMM should lead the workshops, not you! It is appropriate for you to be present, however, to assist the COMM and the participants as needed.

The workshops may follow an agenda similar to the sequence of activities presented here.

WORKSHOP ACTIVITY 1: INTRODUCTIONS

The COMM members and the participants will open the meeting and introduce themselves following whatever protocols are usual in the community. The COMM members should explain their own role as a community health committee for those participants who may not be aware of their work, and then explain that the purpose of the workshop is to hear from community members about important health issues. Later, the COMM and the community will create a plan together. This plan will include actions that can be taken to address the discussed health issues. The COMM will then go through many of the same activities with the workshop participants that you went through with the COMM in Step 1.

WORKSHOP ACTIVITY 2: SETTING THE CONTEXT WITH BASIC MATERNAL AND CHILD HEALTH INDICATORS

The COMM will carry out this activity with the workshop participants by posting the prepared flipchart pages with the indicators for discussion of what is happening in the country. The group will go through the indicators one by one, just as you did with the COMM in Step 1. The COMM will be the experts now!

The COMM will allow time for the participants to think about and discuss what is happening in their community and how this corresponds to the national situation. What health issues are the most serious nationally? What health issues are the most serious in their community?

WORKSHOP ACTIVITY 3: COMMUNITY MEMBERS' HEALTH PRIORITIES

The COMM will divide the workshop participants into three or four smaller groups and ask each group to answer the question:

- What health issues in this community are of most concern to you personally and to your families?

The small groups may first brainstorm to come up with a full list of health issues, perhaps writing these on flipchart paper, and then prioritise the **three** they feel are most important. When all small groups are finished, the groups will present their lists in the large group, to generate a final list of priorities. There will likely be duplicates among the groups; the final list should remove the duplicates.

Workshop Activity 4: Ideas About the Root Causes of the Prioritised Issues

Each small group will work on two or three prioritised health issues. The COMM will lead the groups to create Bubble Maps for each health issue, as the COMM itself did during Step 1. The COMM members should walk around and help the groups.

When all groups have finished they will present in the large group. This activity should be summarised by making a list of the numerous root causes of health issues in the community. The COMM should allow time for discussion and debate, and save the flipcharts to present in the community debriefing and planning meeting (Step 6).

Workshop Activity 4b: If Relevant, Supplement with Select 7-11 Health practices

Depending on the issues that the group has prioritised, the COMM will review the underlying health practices that may be contributing to the health issues, per the list in Tool 3a-2. For example, if malaria is prioritised, the COMM will review the behavioural practices listed under the malaria category; both for pregnant women and for children.

If the workshop participants have identified issues that are different from the ones the COMM identified in Step 1, it may be necessary for you, the facilitator, to assist with some background information.

The COMM will explain that the failure to carry out these health practices may be contributing to the identified health problems, and the group can add this to their analysis. The COMM will help the participants to create a flipchart table similar to the one the COMM made in Step 1:

- Make four columns on flipchart paper. In the first column, list the 7-11 practices related to the identified health issues.
- Participants self-assess: for each of the health practices, do they personally (or their spouses or family members) practice the behaviour? Each participant puts a tick in the second column if so.
- For those behaviours not practiced, what are the reasons why not? What makes it difficult to practice these behaviours, both for themselves and for other community members? These are 'barriers'. Write the barriers in the fourth column.
- For those behaviours not practiced, what sorts of things would make it easier to practice them? These are 'enablers'. Write the enablers in the fifth column. Save the flipchart paper for later.

Workshop Activity 5: Reflecting and Learning, and Explain Next Steps

The COMM and the participants should take some time to reflect on and share about the exercise and the process. Then, the COMM will explain that when the remaining workshops and interviews have been completed and all the information has been gathered, the COMM will organise a community meeting open to all, to discuss the results and come up with an action plan together. The flipcharts and information recorded by the participants in this workshop will be used in the community meeting.

STEP 4: HEALTH FACILITY INTERVIEW

Notes for the Facilitator

In this step you will work with Tool 3a-7, Local Health Facility Interview Guide, to help the COMM conduct an interview with the local health facility to understand the services provided there.

It is important to note that it will not be possible in all circumstances for every COMM to carry out a clinic interview. This is because the catchment area of the health clinic may cover three or four or more COMMs; in those cases only one of the COMMs should do the interview. This will normally be the COMM located closest to the clinic. When it has completed the interview, the facilitator should distribute the information to the other COMMs in the area.

You may need to help make arrangements with the clinic, assisting with introductions, explaining the work and the purpose, and requesting staff time. The COMM may either go to the clinic, or perhaps one or two clinic members would be willing to come meet with the COMM during the training.

ACTIVITY 1: REVIEW TOOL 3A-7: LOCAL HEALTH FACILITY INTERVIEW GUIDE

Review Tool 3a-7, Local Health Facility Interview Guide, with the participants. The COMM will use this form with clinic staff in order to gather information about the services available at the clinic, as part of the research into the community health issues. Review the form and answer any questions.

If the COMM you are training today is the one that will interview the clinic staff, have the group spend time practising with the interview guide. Go through the tool question by question. Emphasise that the group is trying to learn about the health services that are available in the area. Sometimes the lack of a necessary service is the barrier that prevents an individual from carrying out positive health practices. These are the types of root causes the COMM is trying to uncover. Spend time practising and assisting the COMM members with any difficulties they may have.

ACTIVITY 2: COMM CARRIES OUT HEALTH FACILITY INTERVIEW

As per the note above, if there is more than one COMM in the health facility catchment area, only one of the COMMs will actually carry out the interview. Assist the COMM as needed in the planning and logistics of this interview.

When the COMM has completed the interview, provide copies of the information to the other COMMs.

ACTIVITY 3: REVIEWING THE INFORMATION

The COMM should meet to review the information from the health facility interview and summarise it for presentation in the community-wide meeting. There are many ways the COMM can present the results; it is up to the COMM. Perhaps the COMM wants to list all of the existing services (to focus first on the positive assets) and then list any gaps that were uncovered.

STEP 5: ANALYSING AND PREPARING THE INFORMATION

ACTIVITY 1: REVIEWING AND PREPARING INFORMATION FOR PRESENTATION

Prior to the community-wide meeting, the COMM should analyse and reflect on the information it has collected. The members should then prepare this information for presentation in the community-wide meeting. A suggested process would be to collect all information documented on flipcharts or other documents and organise for presentation:

1. the basic maternal, newborn and child health indicators (from Tool 3a-1)
2. a listing of the main health issues identified by the various stakeholders (COMM, general community members, more vulnerable community members, health staff) in Steps 1, 3 and 4
3. the flipcharts with all of the Bubble Maps (root causes)
4. the flipcharts with the analysis of the selected 7-11 practices, if applicable
5. a summary of identified barriers and enablers
6. a summary of health facility services.

ACTIVITY 2: THINKING AHEAD TO WHO CAN RESPOND

During the community-wide meeting, the COMM and the community will come up with a draft action plan for responding to the identified health issues. To help the COMM think ahead to this, review the following four points.

1. Remind the COMM of the '360 degrees' framework that distinguishes between actions taken at individual, community and 'enabling environment' levels.
2. Discuss the types of issues (or barriers) that are found at the individual level and that may be addressed directly with family members in their homes. These may include such things as incomplete or incorrect knowledge about the health issue, harmful or unhelpful beliefs, or imbalances within the family (for example, males may eat better).

   These kinds of issues are often best addressed by CHWs or other health volunteers who interact with families at this individual level.
3. Discuss the types of issues or barriers that are best addressed at the community level. These are barriers that the CHWs and families are not able to solve or overcome during household visits. These may include such things as transport constraints, food insecurity, or water access, for example.

   These types of issues may sometimes be addressed by the COMM, often by means of wider community mobilisation. Consider what the COMM and the community can do together to help address such issues.

   Other types of barriers also best addressed at the community level are those related to social, cultural or religious norms; that is, when many or most members of the community behave or do things in a certain way because that is what is accepted as normal in the context. Changing these types of behaviours or barriers cannot easily be done at the household level, but rather, involve thoughtful, transformative processes.

   It may not be possible for the COMM to directly take on issues related to social, cultural and religious norms, but the COMM can be active in bringing in specialised programmes. In the case of World Vision-linked COMM programmes, it is highly recommended that World Vision staff guide the COMM to request Channels of Hope programming to engage the faith community in norms-related issues.

4. Discuss the types of issues or barriers that relate to the enabling environment; that is to say, that relate to health services, supplies or policies. These are barriers that cannot be solved at the household level, nor through actions that COMMs and community members can undertake by themselves.

   These issues are usually best addressed through local advocacy, initiated by COMMs and communities (with World Vision or other support), to bring about action on the part of the government, the ministry of health or the local clinic staff. If health staff are actively participating in the COMM activities and community meetings, they can also take responsibility for some actions and responses.

Summarise this discussion by copying the following table onto a flipchart.

Table 1: Who Can Respond to Barriers

Level	Examples of Barriers	Who and How to Respond
Individual	• Lack of health knowledge • Inaccurate health knowledge or beliefs • Family practices • Influence of others, such as husbands, grandmothers	• CHWs or other health volunteers
Community	• Transport constraints • Food insecurity • Water access • Community sanitation	• COMM with community mobilisation
Community	• Social, cultural, religious norms	• Transformative programming, such as Channels of Hope or Community Conversations
Environment	• Lack of health services, or poor quality • Lack of health supplies • Need for additional health policies	• Local advocacy • Health staff

Now have the COMM look at the Bubble Maps and lists of barriers they have collected. Discuss and try to identify if each barrier can be addressed at the individual, community or wider environmental level. Reinforce the point that the different levels and types of barriers, or root causes, will require different types of response and action, and the COMM will not do everything by itself! The COMM can begin to think about the kinds of actions the COMM and the community can take, but they will not make decisions at this time.

STEP 6: COMMUNITY DEBRIEFING AND PLANNING MEETING

Notes for the Facilitator

It is essential that the COMM holds a debriefing meeting with the community to validate or correct the findings from the previous steps and increase ownership over the process and its results. The debriefing process should include a presentation of the results and discussion of the future steps.

Decisions on who to invite are very important. The COMM should try to bring together all the key health duty-bearers, stakeholders and the community members that participated in the analysis process. All those who hold positions of relevant power and influence should be invited, since this is also an important opportunity for them to hear the voices of community members and to be engaged in response. A typical meeting of this kind may include up to 100 to 200 people and can last an entire day. Lunch should be prepared.

Facilitation of the community-wide meeting is a challenging job. You and the COMM members will need to manage group dynamics as community and service provider views are brought together. The COMM will need to create an environment that enables people's views to be heard.

At the same time the COMM will need to ensure that the participants commit to proposals and take responsibility for actions. Therefore, it is a good idea for you to meet with the COMM ahead of time to determine what to expect, and how the COMM will deal with challenging situations.

COMMUNITY MEETING ACTIVITY 1: INTRODUCTIONS, PURPOSE, PROCESS

The COMM members will introduce the purpose of the meeting to the community and explain that they will review the results of the exercises they have carried out with some community members. It is important that all attendees understand that the COMM will request the attendees' contribution towards an action plan to respond to the identified health issues.

COMMUNITY MEETING ACTIVITY 2: PRESENTATIONS, DISCUSSION AND REVIEW OF FINDINGS

The COMM, as well as those community members who were involved in the workshops, will present their information and results.

- The COMM should begin by reviewing the basic maternal, newborn and child health indicators.
- Next, the health issues identified during the workshops should be reviewed, and the contributors can explain their Bubble Maps and other analyses.
- This is also an opportunity to present the issue of birth registration.
- Opportunities should be given for participants to provide feedback and comments and to ask for more explanations about the data being presented. At this stage, only allow questions of clarification; delay opportunities for discussion and decisions about what action to take until the next part.
- Finally, the flipcharts can be posted on the walls, and attendees can walk around freely and review the findings on the flipcharts.

COMMUNITY MEETING ACTIVITY 3: ACTION PLANNING

The COMM will now lead the participants to focus on the main health issues and the root causes or barriers. A suggested process could be the following, but this is not mandatory nor the only way to proceed. The COMM should do what makes sense.

1. Introduce the 360 degree framework and review the different levels of health issues or barriers (individual, community, environment). Discuss who can best respond at which levels. For example, CHWs can respond at the individual level, the COMM and community members at the community level, and health clinic staff at the environmental level.

2. Pass out stickers, dots or markers of different colours and lead an activity of marking the root causes or barriers listed on the flipcharts with a colour, based on the most appropriate respondent. For example, red might indicate CHWs, blue the COMM, and yellow health workers. The facilitators can decide how best to organise this, in small groups or as a large group.

3. Then, divide into groups by type, with all CHWs and volunteers in one group, all health workers in another, and so on. Distribute the flipcharts among the groups according to the colours; for instance, CHWs would receive those marked as red. Each small group should consider the ways that it can contribute to the overall action plan and should list its ideas.

4. The COMM then leads a session with all attendees to put together one overall draft action plan. Write on flipcharts or gather flipcharts from the small groups and combine them, omitting duplications. The group should try as far as possible to create SMART action plans that are Specific, Measurable, Achievable, Realistic and Time-bound.

Start small! Encourage the community to set realistic goals. Communities that choose goals that are too ambitious are likely to become easily discouraged. Experience shows that as communities become more skilled in their work, they can set more ambitious goals.

Note for the Facilitator: Following Up and Moving Forward

Most likely, the COMM and the community will be able to develop a draft action plan at this time, but there may be more that the COMM needs to do to finalise the details afterwards. It is also possible that because the COMM members were busy facilitating the meeting, they weren't able to think through their own responsibilities and actions with enough time, and they need to take more time to come up with their comprehensive plan.

You should follow up by carrying out part or all of Session 4 with the COMM, in order to focus on the COMM's action plan. There may be a lot of overlap between the suggestions and activities in Session 4 and the meeting that just took place. Use your judgment! If parts of Session 4 have already been handled in the community-wide meeting, skip them! If parts of Session 4 were not handled in the meeting and are important for the COMM to consider, carry them out! For example, the COMM might find the Bookkeeping activity in Session 4 very useful, and this might not have come up at all in the meeting.

At the very least, make sure that the COMM ultimately writes or transfers its action plan to Tool 4-3, COMM Action Planning and Monitoring Tool: Responding to Health Issues and Barriers, found in Session 4. This should be the primary product coming out of the activities in Sessions 3 and 4.

TOOL 3A-1. KEY HEALTH AND NUTRITION CONCERNS

Indicators	Level of Concern			National-Level Data	Local-Level Data (if available)
	L	M	H		
Mortality Indicators					
Under-5 mortality rate (U5MR): per 1,000 live births	≤20%	20–39%	≥40		
Infant mortality rate (IMR): per 1,000 live births	≤20	20–39%	≥40		
Neonatal mortality rate (NMR): per 1,000 live births	<15%	15–20%	>20%		
Maternal mortality ratio (MMR): per 100,000 live births	<100	100–300	>300		
General Nutrition Indicators					
Newborn low birth weight (LBW) % newborns with low birth weight (<2500 grams)	<10%	10–15%	>15%		
Height/length for age (HFA) (Stunting) % children 0–59 months stunted (HAZ < -2) CWB)	<20%	20–29%	≥30% (very ≥40%)		
Weight for height (WFH) (Wasting) % children 0–59 months wasted (acute undernutrition) (WHZ < -2)	<5%	5–9%	≥10% (very ≥15%)		
% of infants under 6 months who are exclusively breastfed	>80%	60–80%	<60%		
Micronutrients					
% of children 6–59 months with anaemia (Hb<11g/dL)	<5%	5–39%	≥40%		
% of women of reproductive age (15–49 years) with anaemia (Hb<12g/dl for non-pregnant; Hb<11g/dl for pregnant women)	<5%	5–39%	≥40%		
% of children 6–59 months who received a high dose of vitamin A supplement (VAC)	>80%	75–80%	<60%		
% of households with access to iodised salt	>90%	70–90%	<70%		

(Tool 3a-1 continued)

Indicators	Level of Concern			National-Level Data	Local-Level Data (if available)
	L	M	H		
Maternal and Reproductive Health					
Percentage of women age 15–49 years attended ANC at least four times during pregnancy	>60%	40–60%	<40%		
% of births attended by skilled birth attendant	>70%	30–70%	<30%		
Family Planning					
Total fertility rate	2	3–5	>6		
Contraceptive prevalence % of women age 15–49	>35%	25–35%	<25%		
Adolescent fertility rate (births per 1,000 women age 15–19)	<30	30–100	>100		
Disease Burden (not HIV)					
Immunisation coverage in children	>80%	75–80%	<75%		
Diarrhoea prevalence in the last 2 weeks for births in the 3 years before the survey	<15%	15–40%	>40%		
% of children under 5 with suspected pneumonia taken to appropriate health provider	>70%	60–70%	<60%		
Proportion of population in malaria risk areas using effective malaria prevention measures					
Prevention of Mother to Child Transmission of HIV					
Adult HIV prevalence (age 15–49) Proxy for HIV prevalence in pregnant women	<1%	1%–4%	>4%		
Estimated % of pregnant women living with HIV who received ARV to prevent mother to child transmission	>80%	60–80%	<60%		
Water, Sanitation and Hygiene					
% of population with year-round access to improved water source (MDG 7.8)	>90%	60–90%	<60%		
% of population using improved sanitation facilities (MDG7.9)	>70%	60–70%	<60%		
Other					
% Birth registration	>98%	91–98%	<90%		

TOOL 3A-2. LIST OF 7-11 PRACTICES

Pregnant Women: Adequate Diet

- ☐ pregnant women take one additional meal and an extra nutritious snack each day
- ☐ families use iodized salt

Pregnant Women: Iron-Folate and Deworming

- ☐ pregnant women take iron-folate tablets every day for at least six months during pregnancy
- ☐ pregnant women consume locally available, iron-rich food such as fish, red meat, green leafy vegetables
- ☐ pregnant women seek and take deworming tablets
- ☐ pregnant women wear shoes

Pregnant Women: Infectious Disease Prevention

- ☐ pregnant women go for their tetanus toxoid injections
- ☐ pregnant women choose to get HIV testing and deliver at a facility
- ☐ TB+ pregnant women register with Directly Observed Treatment Short Course Strategy (DOTS) and follow treatment, completing the drug regime

Pregnant Women: Malaria

- ☐ pregnant women sleep under a specially treated bed net every night
- ☐ pregnant women receive two or more doses of malaria prevention at the health clinic during their pregnancy
- ☐ pregnant women with malaria are treated with correct drugs/medication

Pregnant Women: Birth Preparation

- ☐ pregnant women work less, rest more
- ☐ households prepare for birth with clean supplies at home for mother and infant, and transport is pre-arranged
- ☐ families are prepared to go quickly to a facility if the woman experiences a danger sign or complication
- ☐ husbands and families have access to financial resources for expenses related to the delivery
- ☐ women avoid smoking, alcohol and illicit drugs during pregnancy

Pregnant Women: Health Timing and Spacing of Pregnancies

- ☐ couples know about the health risks and benefits of using a family planning method
- ☐ couples who desire another pregnancy after a live birth wait 24 months (preferably 36), but no more than 53 months

Pregnant Women: Health Services – Antenatal Care

- ☐ pregnant women seek/demand antenatal care (ANC) services
- ☐ husband/partner or other family member accompanies pregnant woman to ANC visits
- ☐ pregnant women choose to get HIV testing and deliver at a facility

(Tool 3a-2 continued)

Pregnant Women: Health Services – Skilled Birth Attendant

- ☐ pregnant women and their families consider it a priority to give birth at a health facility

Pregnant Women: Health Services – Postnatal Care

- ☐ women go to health facility for postnatal care for themselves and their newborn babies

Children Under 2: Essential Newborn Care

- ☐ mothers practise cleaning of eye and cord care
- ☐ mothers put baby to breast, wrap and cuddle skin to skin

Children Under 2: Appropriate Breastfeeding

- ☐ mothers feed the baby exclusively breast milk until baby reaches 6 months of age
- ☐ mothers continue to breastfeed their child for up to 24 months
- ☐ mothers continue and increase breastfeeding during child's illness
- ☐ mothers breastfeed on demand
- ☐ mothers give the colostrum to their babies
- ☐ mothers give no liquids or other foods before breast milk is offered
- ☐ caregivers do not give the child any bottles

Children Under 2: Hand Washing with Soap

- ☐ families understand the importance of toileting facilities and use them
- ☐ families understand the importance of keeping a clean hand-washing station with an effective product (soap, lime/lemon or ash) in or near the house and use it
- ☐ caregivers wash hands with soap before cooking, eating and feeding baby and after toilet and disposal of faeces

Children Under 2: Appropriate Complementary Feeding

- ☐ caregivers provide a variety of food that includes animal-source foods using responsive feeding techniques
- ☐ caregivers understand the function of the growth card and take child to growth monitoring every month until immunisations are completed, then every 2-3 months

Children Under 2: Adequate Iron, Anaemia

- ☐ caregivers recognise local, iron-rich foods (animal-source including insects and fish, and dark green leafy vegetables) and feed to the child, or give iron-fortified complementary food

Children Under 2: Vitamin A Supplements

- ☐ caregivers give vitamin A-rich foods to their children, including fruits or vegetables (yellow or orange in colour) and animal-source foods
- ☐ caregivers seek vitamin A capsules for children 6-59 months old

(Tool 3a-2 continued)

Children Under 2: Oral Rehydration Therapy (ORT) and Zinc

- ☐ caregivers understand that children with diarrhoea need more fluid and for children under 6 months, this is breast milk only
- ☐ caregivers practise threefold oral rehydration therapy (ORT) approach: oral rehydration solution (ORS); zinc; continued breastfeeding and complementary foods, if appropriate
- ☐ caregivers recognise the signs of severe dehydration and take the child to a healthcare facility for skilled care
- ☐ caregivers know definition of diarrhoea (three or more liquid stools per day) and signs of dehydration

Children Under 2: Malaria

- ☐ caregivers recognise the danger signs of malaria and take child to the health facility
- ☐ when child is given anti-malarials, caregivers ensure that child takes medication promptly
- ☐ caregivers keep children under bed nets (LLINs) every night

Children Under 2: Full Immunisation for Age and De-worming

- ☐ caregivers seek immunisations at health facility
- ☐ caregivers ensure that the child's health card is updated after each visit to the clinic and keep the card safe
- ☐ caregivers ensure child receives de-worming medication starting at 12 months of age
- ☐ caregivers ensure that when child begins to walk, he or she wears shoes

Children Under 2: Acute Respiratory Infection

- ☐ caregivers recognise the danger signs of pneumonia and take child to health facility
- ☐ caregivers seek treatment for pneumonia in children and complete the full course of medication

Children Under 2: Paediatric HIV and TB

- ☐ infants born to HIV+ mothers are tested four to six weeks after delivery and receive appropriate care (PMTCT)
- ☐ caregivers recognise the importance of infants born to HIV+ mothers getting specialised PMTCT services
- ☐ family members understand the correct ways to prevent mother-to-child transmission of HIV

Children Under 2: Birth Registration

- ☐ Caregivers register the infant's birth during the first month of life.

TOOL 3A-3. HOW DOES IT FEEL TO BE A VULNERABLE CHILD?

Recommended Process

1. Create a calm atmosphere, ask the participants for silence.

2. Hand out the role cards at random, one to each participant. Tell them to keep the cards to themselves and not to show them to the others. Each participant will act out the role on their card.

   Note: These roles can be changed to fit the local situation. However, there should always be a mix with a majority of roles describing vulnerable situations, a small percentage in moderately good situations, and a couple that are in privileged positions.

3. Now, ask the participants to begin to get into their roles. To help, read out some of the following questions, pausing after each one, to give people time to reflect and build up a picture of themselves and their lives.

   - What is your childhood like? What sort of house do you live in?
   - What kinds of games do you play? What sort of work do your parents do?
   - What do you do in the morning, in the afternoon, in the evening?
   - How much money do your parents earn each month?
   - How do you contribute to the family livelihood?
   - What do you do in your free time, if you have any?
   - What do you do in your holidays, if you have any?
   - What excites you and what are you afraid of?

4. Now ask the participants to remain silent as they line up beside each other (as on a starting line for a foot race).

5. Tell the participants that you are going to read out a list of situations or events. Every time that they can answer 'yes' to the statement, they should take a step forward. Otherwise, they should stay where they are and not move.

6. Read out the situations one at a time. Pause for a while between each statement to allow people time to step forward and to look around to take note of their positions relative to each other.

7. At the end have everyone take note of their final positions. Before discussing the exercise remind them that they are now 'themselves' again.

Statements

- Your family has never encountered any serious financial difficulty.
- You have a decent house with a television.
- You feel your language, religion and culture are respected in the society where you live.
- You feel that your opinion on social and political issues matters, and your views are listened to.
- You have never felt discriminated against because of your origin.
- You have adequate social and medical protection for your needs.
- Your family provides high levels of love and support.
- You can buy new clothes at least once every three months.
- You can fall in love with the person of your choice.
- You can use the Internet.
- You receive support from three or more nonparent adults or peers.
- You go to church regularly or attend another religious institution.
- You go to a school which provides an encouraging, caring environment to learn.
- You have caring neighbours.

(Tool 3a-3 continued)

- You feel safe at home, at school and in the neighbourhood.
- Your best friends model positive, responsible behaviour.
- You are encouraged by parents and other adults to do well.
- You spend time in cultural or recreational activities with other young people.
- You are optimistic about your future.

Debriefing

Start by asking participants about what happened and how they felt during the activity. Then talk about the issues raised and what they learned. Before they answer the questions, have them share what their role was. Some key questions:

- How did you feel during the exercise?
- How did it feel to step forward? To be left behind? What did this make you feel about yourself and others?
- What reflections do you have about exclusion and vulnerability from this exercise?

Role Cards

Daughter of a banker, attending a private school. You sponsor a child and write regularly.	**Son of a local businessman and recent immigrant. You attend school. You are bullied by your peers.**	**Boy working in a brick factory. Your parents are indebted to local moneylenders.**
Adolescent boy in a juvenile reform centre. Your father is an alcoholic and abusive.	**Girl who has been trafficked by her uncle. You are trapped in prostitution and unable to communicate with your family.**	**Boy in primary school. Your father is a fisherman and a village elder. You help fish on weekends.**
Girl who has been displaced by conflict. You help your mother teach out-of-school children.	**Adolescent boy whose parents died of AIDS. You care for three siblings.**	**Son of a government minister. Attending a private boarding school.**
Adolescent girl whose boyfriend is a gang member. You have dropped out of school.	**Boy who is fighting for a rebel militia. Your family was killed by government forces.**	**Boy being raised by a single working mother. You are cared for by your grandparents.**
Boy living and working on the streets. Your stepfather beats you. You sniff glue.	**Adolescent girl elected president of the local children's parliament. You help your mother roll cigarettes.**	**Disabled boy who is carried by your father to school each day.**
Boy who lives with parents and five siblings in a slum.	**Girl who is HIV positive. You are cared for by your grandparents. You are barred from school.**	**Adolescent boy in a rural setting. Your father is a local pastor. You help lead the children's group in your church.**
Girl in high school. Your mother works in a textile factory. You are pregnant.	**Girl adopted by Hollywood star. You lost both parents to AIDS.**	**Daughter of missionary parents who have lived for years in a remote village.**

TOOL 3A-4. WHO ARE THE VULNERABLE FAMILIES IN OUR AREA?

Recommended Process

You have now looked at what it means for children to be vulnerable in this area. Now, you will look at which families are vulnerable in your communities.

Consider the following questions together and develop a list of the groups (or types) of most vulnerable children from the discussion.

- Which families are living in the worst situations in this community? Why?
- Which families face the most discrimination in this community? Why?
- Which families and children have the lowest possibility of a good future? Why?

Initially, you should try not to give any examples, but if the group is really struggling with these questions, you may give one to two examples so that they understand the exercise (such as, a family is vulnerable if one or both parents is chronically ill; or a family is vulnerable if they belong to a particular tribal minority group).

After the list is generated you can use the list below (considering the local context and which of these are relevant) to help the group consider if there are families or children in the area who are:

- living or working on the streets
- sexually exploited
- without a primary caregiver
- affected by HIV and AIDS
- affected by armed conflict
- affected by natural disasters
- involved in gangs
- using drugs
- affected by domestic violence
- victims of stigma and discrimination
- affected by alcohol abuse in the family
- affected by stigma associated with disability
- discriminated against because of ethnic or religious group
- landless
- living with a chronically ill family member
- in a child-headed household
- children married at a young age
- immigrants or refugees
- a family with women who sell sex
- households that have taken in orphans
- households in which the children are not in school.

After the list has been developed, discuss how the COMM would prioritise the vulnerability of the different groups. Which groups are more vulnerable than others? Recognise that different participants may have different perspectives and views.

TOOL 3A-5. WHERE ARE THE MOST VULNERABLE? MAPPING VULNERABILITY

Recommended Process

Ask the participants to form into small groups based on their knowledge of specific geographic areas, such as neighbourhoods, villages or communities. They should group themselves based on the areas they know best.

Provide each group with a large sheet of flipchart paper, or several sheets taped together. Ask each group to draw their assigned geographic area. Using the information from the previous exercises, ask the groups to draw on the map the places where the most vulnerable families are located.

Ask the groups to also include on the map:

- individuals, groups or organisations that work with and help the most vulnerable
- places of risk in the community
- places of safety
- places where children gather during the day and night.

When the groups have completed their maps, post the maps on the wall and ask each group to share about their geographic area. Discuss similarities and differences between the areas. Add anything that comes up during the discussion.

After all the groups have shared, look again at the list of vulnerability factors developed in the previous exercise. Ask the participants to think about and discuss the factors. Is there anything missing? Add factors if needed.

Conclusion

Explain that these exercises will help the COMM to know who to include in the upcoming community workshops.

TOOL 3A-6. COMM ACTION PLANNING AND MONITORING TOOL: SITUATION ANALYSIS: IDENTIFYING HEALTH ISSUES FOR ACTION WITH THE COMMUNITY

IDENTIFYING HEALTH ISSUES FOR ACTION WITH THE COMMUNITY

Name of COMM: _____Year: _____ Quarter: Q1 _____ Q2 _____ Q3_____Q4 _____

Instructions: Fill out the table below with the activities the COMM will undertake to achieve the goal of identifying health issues for action with the community. Tick the box under 'Goal' only when the activities are complete and the goal has been achieved.

Goal

☐ A participatory situation analysis has been carried out and health issues for action have been identified and prioritised together with the community.

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

(Tool 3a-6 continued)

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

TOOL 3A-7. LOCAL HEALTH FACILITY INTERVIEW GUIDE (EXAMPLE)

No.	Question
Section 1: Staffing	
1.1	How is this facility staffed? (Ask for numbers for each) ☐ Doctor or visiting doctor ☐ Nurses ☐ Midwives ☐ VCT counsellors ☐ CHWs ☐ Phlebotomist ☐ TBAs ☐ Other outreach worker (describe)
1.2	How would you describe the situation in terms of staff turnover or staff loss?
Section 2: General	
2.1	What is the catchment area and/or population for this health facility?
2.2	How many kilometres to the furthest village or town?
2.3	Where and what type is the nearest referral facility? What is the distance in kilometres?
2.4	How are patients transported to the referral facility?
Section 3: Services	
3.1	What services are provided for pregnant and lactating women? ☐ Antenatal care ☐ Postnatal care (describe) ☐ Family planning (describe) ☐ Voluntary counselling and testing services ☐ Prevention of maternal-to-child transmission ☐ Anti-retroviral treatment ☐ Maternity/delivery ☐ Emergency obstetric care (describe)

(Tool 3a-7 continued)

3.2	What child health services are provided? ☐ Under-5 health education ☐ Growth monitoring ☐ Immunisations (list) ☐ Vitamin A ☐ De-worming ☐ Iron supplementation ☐ Early infant diagnosis of HIV ☐ Cotrimoxizole for infants suspected of being exposed to HIV ☐ Paediatric anti-retroviral treatment
Section 4: Antenatal Care	
4.1	What services are provided during antenatal care visits? ☐ General check-up ☐ Iron-folate tablets ☐ Tetanus toxoid injections ☐ Intermittent preventive treatment in pregnancy for malaria ☐ De-worming ☐ Testing for HIV ☐ Testing for TB ☐ Testing for sexually transmitted diseases (STDs)/syphilis ☐ Prevention of maternal-to-child transmission ☐ Other (describe)
4.2	In what stage of pregnancy do most women in the community seek antenatal care? (probe for reasons)
4.3	What percentage of pregnant women are adolescents; that is, women under the age of 18?
4.4	How often do male partners accompanying women during antenatal care visits?
Section 5: HIV, Prevention of Mother-to-Child Transmission	
5.1	Is providing education about preventing HIV a part of antenatal services?
5.2	What is the uptake of prevention of maternal-to-child transmission services (if provided)?
5.3	Are male partners involved in prevention of maternal-to-child transmission education?

(Tool 3a-7 continued)

5.4	Is lifelong anti-retroviral treatment available for all pregnant women with advanced clinical disease? Where?
5.5	Are combination anti-retroviral prophylaxis available beginning in the second trimester and linked with postpartum prophylaxis?
5.6	Is anti-retroviral prophylaxis available for mother and/or infant during breastfeeding?
Section 6: Deliveries	
6.1	On average, how many deliveries are conducted at the facility per month?
6.2	What is the procedure for emergency complications? (probe for ability to handle at clinic versus need for referral and transport for referral)
Section 7: Postnatal Care	
7.1	How long do mothers and the newborn remain in the clinic postpartum?
7.2	What are the protocols for postpartum and newborn check-ups?
7.3	Are there outreach services/home visitations performed by CHWs during the first week of life? (If so, describe)
7.4	Does the clinic give a high dose of vitamin A to postpartum women? If so, when?
Section 8: Healthy Timing and Spacing of Pregnancies	
8.1	What contraceptive methods are available in this facility?
8.2	What is the uptake of these services? (How much are people actually seeking and using these services?)
Section 9: Maternal and Child Mortality and Morbidity	
9.1	What are the main causes of death for pregnant women and mothers during and immediately after child delivery?
9.2	What are the main causes of death for newborns, infants and children under 2 and under 5 in this area?
9.3	What are the main childhood illnesses treated at this facility?
9.4	What is the prevalence of malaria in this area? What is the malaria treatment protocol?
9.5	How is diarrhoea treated? (probe for zinc)
9.6	How common is pneumonia in this area?
Section 10: Childhood Malnutrition	
10.1	What services are available for children presenting with: ☐ Moderate malnutrition ☐ Severe malnutrition (probe for HIV testing)

(Tool 3a-7 continued)

10.2	How common are these?
Section 11: Supply Chain and Shortages	
11.1	What is the facility's system for receiving supplies/stocks/medicines? (describe)
11.2	Are there issues of shortages or unavailability related to any of the services discussed? (tetanus toxoid immunisation, iron-folate tablets, intermittent preventive treatment in pregnancy, anti-helminths, contraceptives, testing kits, reagents, vaccines, cotrimoxizole, anti-retrovirals, oral rehydration solution, zinc, antibiotics)
Section 12: Community Service Providers	
12.1	What types of community-based service providers exist, and what kinds of services do they provide?
12.2	How are they coordinated and supervised?
12.3	What kind of referral system exists between the health facility and the community-based service providers? (describe)
Section 13: Other Organisations	
13.1	Is this facility supported by any outside organisations (for example, NGOs supporting voluntary counselling and testing services)? (describe)
Section 14: Challenges	
14.1	What are the main challenges that this facility faces?
14.2	What is being done, or can be done, to overcome these challenges?

Follow-up

When you have completed the interview, ask the respondents if the clinic is able to provide information to the COMM on an ongoing, perhaps quarterly, basis. Explain that you (the COMM) will be tracking the health situation in the area and information from the clinic would be useful for this purpose. Not all clinics will have readily available statistics that they are able or willing to share, but some might.

In the space below, write the agreement you reach with the clinic. What types of information are they able to provide on an ongoing basis? (For example, immunisation statistics, statistics regarding numbers of women attending antenatal classes, and so on.)

Who will collect this information, how often, where, and from whom?

- Who: _____
- How often: _____
- Where: _____
- From whom: _____

FURTHER INFORMATIONASE CONTACT:

WVI Offices

World Vision International Executive Office
Waterview House
1 Roundwood Avenue
Stockley Park
Uxbridge, Middlesex
UB11 1FG, UK

World Vision Brussels & EU Representation ivzw
18, Square de Meeûs
1st floor, Box 2
B- 1050 Brussels, Belgium
+32.2.230.1621

World Vision International Liaison Office
7-9 Chemin de Balexert
Case Postale 545
CH-1219 Châtelaine
Switzerland
+41.22.798.4183

World Vision International United Nations Liaison Office
919, 2nd Avenue, 2nd Floor
New York, NY 10017, USA
+1.212.355.1779

WVI Regional Offices

East Africa Office
Karen Road, Off Ngong Road
P.O. Box 133 - 00502 Karen
Nairobi
Kenya

Southern Africa Office
P.O. Box 5903
Weltevredenpark, 1715
South Africa

West Africa Office
Hann Maristes
Scat Urbam n° R21
BP: 25857 - Dakar Fann
Dakar
Senegal

East Asia Office
809 Soi Suphanimit, Pracha Uthit Road
Samsen Nok, Huai Khwang
Bangkok 10310
Thailand

South Asia & Pacific Office
750B Chai Chee Road #03-02
Technopark @ Chai Chee
Singapore 469002

Latin America and Caribbean Regional Office
P.O. Box:133-2300
Edificio Torres Del Campo, Torre 1, piso 1
Frente al Centro Comercial El Pueblo
Barrio Tournón
San José
Costa Rica

Middle East and Eastern Europe Regional Office
P.O Box 28979
2084 Nicosia
Cyprus

World Vision is a Christian relief, development and advocacy organisation dedicated to working with children, families and communities to overcome poverty and injustice. Inspired by our Christian values, World Vision is dedicated to working with the world's most vulnerable people. World Vision serves all people regardless of religion, race, ethnicity or gender.