World Vision

Facilitator's Manual for Community Health Committees (COMM)

Session 3b: Root-Cause Analysis of Health Issues in the Community (Robust Version)

Field Test Version

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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.

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Toolkit

SESSION 3B: ROOT-CAUSE ANALYSIS OF HEALTH ISSUES IN THE COMMUNITY (ROBUST VERSION)

Notes for the Facilitator

You are working with this COMM because there are root causes of maternal and child health issues in the community. You will start this session by explaining that just as a tree's roots must be strong and healthy for the tree to bear fruit, a community must also look at its own root issues if it wishes to realise its vision for health. In this session you will train the COMM to carry out an analysis of the main health issues in the community. The session is divided into seven steps, outlined below, and seeks to research the following guiding questions:

- What are the priority maternal and child health issues within this community?
- What are the root causes of these issues, both in terms of the practise of healthy behaviours and the existence and quality of health services?
- What are the barriers to the practise of healthy behaviours?
- Who influences the health practices of adolescents, pregnant women and caregivers of young children?
- What are the prevailing attitudes and beliefs in the community about maternal and child health?
- Are there any harmful traditional practices in this community that have an impact on maternal and child health? How prevalent are they?
- What health services exist in the community, and how satisfied are community members with these services?

Step 1: Introduction: Understanding barriers to behaviour change: The COMM will be looking at whether or not community members are practising the 7-11 behaviours, as these will underlie many of the maternal and child health issues in the community. It is important to understand, however, that if individuals are not practising a recommended behaviour, there is usually a good reason for it – some kind of a barrier. In Step 1 the COMM will be introduced to the idea of 'barriers' and understand that it will be important to identify barriers to positive health behaviour.

Step 2: Present national-level and local-level statistics: In Step 2 you will present available statistical data in an understandable way to the COMM and, together with the COMM, use this information to identify the most critical health issues for prioritisation in the research they will be doing in the communities.

Step 3: Train the COMM to carry out focus group discussions: In Step 3 the COMM will learn how to carry out FGDs with pregnant women, caregivers of children under 2, their spouses and other influencers, and adolescents, including the most vulnerable among these groups. The COMM will learn more about the most significant health issues from these discussions and will probe to try to understand the underlying barriers and causes of the issues.

Step 4: Train the COMM to learn from key stakeholders: In Step 4 you will train the COMM to carry out interviews with key individuals who may have unique or specialist knowledge and information about the health issues in the community.

Step 5: Creating an Action Plan: In Step 5 you will help the COMM to develop its action plan for carrying out the root cause analysis, and you will explain how they will use this form to monitor progress.

Step 6: Analysing the information: In Step 6 you will help the COMM to analyse all of the information it has collected and to establish priorities to address the key issues, as possible.

Step 7: Debrief with the community: The COMM can learn how to organise and run regular debriefing meetings in Session 6. In addition to the ordinary debriefing meetings, the COMM should also hold a special (extraordinary) meeting when it has completed the root-cause analysis in order to share its learnings with the wider community.

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 Tools 3b-1, 3b-3 and 3b-5 would need to be adapted. You will need to include indicators relevant to the health issues the COMM is concerned with in Tools 3b-1 and 3b-3, and change the questions in the Focus Group Discussion Guide (Tool 3b-5) accordingly.

Step 1: Recognising Barriers to Positive Health Practices

Activity 1: Introduce the Session

Explain to the COMM that if we want to see improvements in the health of the mothers and children in the community, it will be necessary for some people to change some of the things they do. For example, if a mother doesn't exclusively breastfeed her baby for six months, we hope that we can learn the reasons that are preventing her (barriers) from doing so, so that we can make it easier for her to do this. Now explain that you will be looking at why people sometimes don't change the things that they do things.

Activity 2: Barriers to Behaviour Change

For this activity you will use the example of traveling down a road. You should do this visually, walking a portion of the classroom floor and explaining to participants that you are imagining walking down a road. You are on your personal health 'journey', and the end of the road is your destination.

Example 1: The road:[1] Ask for a volunteer to come forward and stand at the beginning of the 'road'. Explain that this person is setting out on a journey and wants to reach his or her destination. Ask the participants what kind of barriers the person might find along the road. Examples might include a flooding river, fallen trees, boulders, or overturned cars. For each example, you can ask other volunteers to play the role of the obstacle – lying in the road, forming a boulder, and so forth. Encourage discussion based on this example.

> ***Main message of example 1*:** Barriers are common and often prevent us from doing what we want to do or from reaching our destination.

Example 2: Exclusive breastfeeding: Repeat the demonstration, but this time use the example of exclusive breastfeeding. A mother exclusively breastfeeding her child is the destination of the journey; that is, it is the behaviour or the behaviour change that the COMM (and CHW) is promoting. Ask for three or four volunteers to come to the beginning of the road. Ask the first volunteer to begin walking, and then stop. The volunteer should explain what is preventing her from exclusively breastfeeding. For example, the volunteer can say that she is too tired and sit down in the road. The second volunteer can say that her milk is not adequate, so she is supplementing with formula, and also sit down in the road. The third volunteer can say that although she exclusively breastfeeds, her grandmother insists that the baby is thirsty and needs to be given water as well. She should also sit down.

> ***Main message of example 2:*** If mothers and other family members do not practise the recommendations that CHWs and other health workers make, it is usually because there is some kind of barrier. It is important for the COMM and the CHWs to be aware of these barriers in order to respond appropriately.

Example 3: Handwashing with soap: Repeat the demonstration, asking for three volunteers again. The first will say that he or she is lazy and doesn't bother to wash her hands. The second will say that soap is too expensive. The third will say that it is very difficult to get water. These volunteers will all sit down in the road, unable to complete their journey.

[1] Adapted from the *Facilitator's Manual for Training CHWs in Timed and Targeted Counselling (ttC), Module 1,* World Vision International.

Main message of example 3: There are some barriers that the CHW can counsel the families on in the home (such as laziness, expense of soap), while other barriers are not possible to overcome through discussion alone (such as access to water). The CHW will need to elevate these barriers to another level. This is where the COMM comes in. Ask the group to think of ways that a COMM might be able to do something about access to water.

Other examples: You may present more examples, if you wish, to emphasise the main messages. Such examples might include 'good nutrition for a pregnant woman', with a possible barrier being the preference that is sometimes given to men for the best foods; or 'appropriate care for pregnant teenagers', with a possible barrier being shunning by their church leaders. Think of others!

Activity 3: Reinforcing the Information

Have the participants work in pairs. Participants should chat for a few minutes with their partner, giving one or two examples from their own life of something that they know they should do, but that they don't do for some reason. They should explain the reasons, or barriers, which keep them from doing something that they know would be good for them. After the pairs have chatted for a few minutes, ask for one or two volunteers to share their examples with the group.

Activity 4: Summarising Behaviour Change

- Changing a person's behaviour (one's own or that of someone else) is like a journey. Making a change does not usually happen all at once; it is common for it to be a long process, often with barriers along the way. Individuals must be committed to the process in order to reach their destination eventually.
- Having knowledge or information about a behaviour or practice is necessary, but knowledge or information is not always enough to change behaviour. Sometimes we *know* we should do something, but we don't, for many possible reasons. This is something that all people experience in life.
- Even though individuals may have correct knowledge and information, there are often barriers that prevent them from adopting a recommended behaviour. There are many kinds of barriers, including inaccurate beliefs or interpretations of religious scriptures, likes or dislikes, systemic or environmental reasons, as well as the influence of other people. The way that the CHWs and the COMM respond depends on the type of barrier.

Emphasise that the COMM has a vital role to play in responding to barriers that affect adoption of positive health practices. Session 4 will cover a number of activities in which the COMM can engage, or mobilise the community's engagement, in order to address identified barriers, while Session 2 covers how the COMM can support CHWs as they too confront these issues.

Activity 5: Knowledge Assessment for Session 3b, Step 1

As you close Step 1, ask the COMM to respond to each of the following statements as either 'true' or 'false' in order to assess the members' general understanding of the material. Allow the group time to discuss and agree on a collective response to each before it answers. If the group answers incorrectly, you will know that you need to revisit this information with the group before proceeding to the next session.

1. Once individuals *know* that they should change a certain behaviour to improve the health of their family, it should usually be easy for them to make this change. (*Answer: FALSE*)

2. All people, all over the world, experience challenges with behaviour change to some degree or in some form. (*Answer: TRUE*)

3. The COMM should *not* be concerned with the barriers to healthy behavioural practices for individual members of the community, as these barriers are things that each person or family has to deal with on its own. (*Answer: FALSE*)

STEP 2: PRESENT NATIONAL AND LOCAL-LEVEL HEALTH STATISTICS TO THE COMM

Facilitator Preparation for Step 2

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 3b-1)
Make a copy of Tool 3b-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 3b-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 class. 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 be explaining 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 them 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 3b-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 our example, maternal mortality is critical at both the national and the local levels; the numbers are much higher than 300. For stunting, in our example the situation is below critical at the national level, with 19 per cent of all children stunted (green). But it is critical in the local area.

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

Community Data Form (Tool 3b-3)
Now make a copy of Tool 3b-3. This is a long form that lists all of the desired 7-11 healthy behaviours. Whether or not these behaviours are being practised may provide underlying causes for the indicators found in Tool 3b-1. In later phases of this session you will be teaching the COMM how to work with Tool 3b-3. But first, you must do some preparation.

Notice the second column, labelled 'Part 1: Local Statistics: Facilitator Provides'. Here you will fill in as much statistical information as you are able to find. Start with the information from Tool 3b-1. There may not be local-level data for all of the desired behaviours (indicators) listed, but you should fill in whatever there is, using any sources you have available. Has your organisation done any data collection? Have other partners?

Now you are ready to present to the group.

Note: You are presenting in this step only information relating to Tool 3b-1. You will introduce Tool 3b-3 itself later.

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 and write their ideas on a flipchart. 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 around what is happening in the country. (Remember to have the last two columns covered.) Show the first indicator, and point to the red statistic that you found on Tool 3b-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. If the answer is in the green range, it means the situation is not urgent. If it is in the yellow range, it needs attention. If it is red, it is critical. Continue with the next indicator.

Allow time for the group members to reflect 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? How accurate was the group in its estimate of the situation in its country and area? Note any feedback you receive as the group reacts to the information presented. It may be useful to draw upon in later sessions.

Activity 3: Making a Human Graph

Referring to the data for the country (from Tool 3b-1), choose one or two of the indicators of critical concern. To make it easier, choose indicators with even or round numbers in their categories. Ask for ten volunteers, who will organise themselves into a 'graph'. As an example, if the level of stunting is 40 per cent, ask for four of the volunteers to squat down on the floor in the line, as if they were very short. The remaining six will form a second line in a standing position, representing the 60 per cent of children who are not stunted. Make sure the participants understand what the two lines mean in terms of the percentages, which in this example would represent the stunting rate in their country or local area.

Explain that the statistics and information you have just reviewed show the overall health situation in their country. Answer any questions. Explain that in the next step you will be looking at the reasons these health problems exist.

Activity 4: Knowledge Assessment for Session 3b, Step 2

As you close Step 2, ask the COMM to respond to each of the following statements as either 'true' or 'false' in order to assess the members' general understanding of the material. Allow the group time to discuss and agree on a collective response to each before it answers. If the group answers incorrectly, you will know that you need to revisit this information with the group before proceeding to the next session.

1. Health indicators labelled with red are of the highest concern, while those labelled with green are of the lowest concern. (*Answer: TRUE*)

2. It is possible to have indicators reflecting low concern at the national level, yet actually of high concern at the local level and require urgent attention in certain communities. (*Answer: TRUE*)

3. If we think that most children under 2 receive adequate iron in this country and that the issue is of low concern, yet we see from the indicators that only 4 out of 10 children under age 2 (40 per cent) are actually receiving adequate iron and that it is labelled as a critical concern, we still should trust our own views more and not be too concerned about the issue. (*Answer: FALSE*)

STEP 3: TRAIN THE COMM TO CARRY OUT FOCUS GROUP DISCUSSIONS

Notes for the Facilitator

In this step you will work with Tools 3b-3 and 3b-4. Tool 3b-3, Community Data Form, lists the many behaviours needed for the good health of pregnant women and young children. Whether or not these behaviours are being practised will be some of the underlying causes for the indicators you reviewed earlier. Tool 3b-4, Local Health Facility Interview Guide, will be used to conduct an interview with the local health facility to understand the services provided there.

In this phase of the training the COMM will learn how to collect this information. Because of the COMM's linkages with the community and other stakeholders, the COMM can contribute greatly to determining **why** particular indicators are of medium or high concern, **what** the particular behaviours or practices that underlie these indicators are, and **who** the influencers of those practising the behaviours are. That is to say, the COMM can learn to do its own information collection, and its members can learn to fill out Tools 3b-3 and 3b-4 themselves.

TRAINING STEPS

ACTIVITY 1: REVIEW THE PURPOSE OF THE RESEARCH

Explain to the COMM members that they will now be trained to carry out some research in the community to understand more about the root causes of the health indicators they discussed in the previous step. Review the research questions with them.

- What are the priority maternal and child health issues within the community?
- What are the root causes of these issues, both in terms of the practise of healthy behaviours, and the existence and quality of health services?
- What are the barriers to the practise of healthy behaviours?
- Who influences the health practices of adolescents, pregnant women and caregivers of young children?
- What are the prevailing attitudes and beliefs in the community about maternal and child health?
- Are there any harmful traditional practices in this community? How prevalent are they?
- What health services exist in the community, and how satisfied are community members with these services?

ACTIVITY 2: REVIEW TOOL 3B-3: COMMUNITY DATA FORM AND TOOL 3B-4: LOCAL HEALTH FACILITY INTERVIEW GUIDE

Introduce Tool 3b-3, Community Data Form, by explaining that this form covers the behaviours associated with the 7-11 practices, as these 7-11 practices will underlie (or cause) much of what was seen with the indicators presented in Step 2. The COMM will use this form to guide FGDs with the community and interviews with key individual stakeholders in order to understand the extent to which these behaviours are being practised in the community, to discover barriers to adopting the 7-11 practices, and to reveal who the main influencers are.

Look through Tool 3b-3, Community Data Form, together. Explain that they will be using this form to find out the situation in their area regarding the practise of the 7-11 behaviours.

Look first at Part 1 (the first column), where you, the facilitator, filled in the statistics for the local level (for those you were able to find). Tell the participants that this is a good starting point to understanding the situation in their area and that it will help them to decide what they should focus on. Read through the information together.

Now look at Part 2. Explain that they will fill in this column by going to talk to the local health clinic. They will try to get as much information as possible by talking to clinic staff regarding each of the behaviours. They can fill in percentages if the clinic has the data, or they can write 'most', 'many', 'some,' 'few', and so on based on the clinic staff's understanding of the situations.

In Part 3 they will record information from FGDs they carry out with various groups of people. They will not collect information for all of the behaviours; rather, they will make selections. You will explain the procedure for this later.

The last column is for comments relating to the information they receive from clinic staff, from the FGDs, or from any other source.

The form also includes columns labelled Q1, Q2, Q3 and Q4. The COMM will keep track of what happens over time, each quarter, and fill in the information in those columns. The COMM will not carry out a new root-cause analysis every quarter, however. Rather, they will get this information from CHWs. The COMM will not discuss these columns at this time. They will be explained in another session.

Now look at Tool 3b-4, Local Health Facility Interview Guide. The COMM will use this form *only* with the clinic staff (not the community) in order to gather information about the services available at the clinic. Explain that sometimes households may not practise a recommended behaviour because they need a service at the clinic that is unavailable or of poor quality. This interview guide helps to learn about those services.

Activity 3: Speaking with Clinic Staff: Community Data Form and Facility Interview Guide

Note: 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.

Note: You will need to make arrangements with the clinic. Because the COMM will be carrying out two interviews (Tools 3b-3 and 3b-4) it may be better to identify separate people for each as respondents, so as not to burden any one clinic staff member. 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.

If the COMM you are training today is the one that will interview the clinic staff, have the group spend time practising with the two interview guides. First, go through Tool 3b-3 and help the group members practise the questions to make sure they are comfortable with them. Explain that if the clinic has statistical data for any of the behaviours, the COMM member should write the data in the column. (For example, 'Pregnant women with malaria are treated with correct drugs or medication' is information the clinic should have.) If there are no clinic records for a particular behaviour, but the clinic staff have a good understanding of the issues, the COMM can write in their answers as 'most', 'some', 'few', and so on, and include comments in the 'comments' column. There will be some questions that the clinic staff may not be able to answer; for example, they will not have first-hand information about what happens in the homes.

Then go through the Tool 3b-4, Local Health Facility Interview Guide, question by question. Emphasise that they are 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.

Note: Do not proceed with the training until the COMM has completed the clinic interviews. This means that you will have a pause in the training at this point.

Activity 4: Selecting Behaviours to Research

Now you will focus exclusively on Tool 3b-3, Community Data Form, for the time being. Looking at Tool 3b-3, the COMM now has two pieces of information to work with:

- the local-level statistics provided by you, the facilitator (Part 1)
- the local-level statistics and information provided by the clinic staff (Part 2).

Look through Tool 3b-3 together with the COMM members. Based on the information they have at this point, they will be able to identify the most common or serious health issues in the community. You and the COMM together should select the behaviours that the COMM wants to study. It is not necessary for the COMM to collect information for all of the behaviours on Tool 3b-3, so help the COMM make a reasonable selection based on the most important health issues. You may also need to ask a health technical staff person to assist them in making these decisions.

Type up a revised version of Tool 3b-3 with only those indicators and behaviours that the COMM selected, and give this new version to the COMM members as soon as you can. Explain that the COMM will collect this information by carrying out FGDs with pregnant women and caregivers of children under 2. In addition, COMM members can carry out FGDs with groups of fathers, adolescents, CHWs and faith leaders. You will review all of this in a later activity.

ACTIVITY 5: LEARNING ABOUT FOCUS GROUP DISCUSSIONS

1. Discuss the Advantages and Disadvantages of Focus Group Discussions

Introduce FGDs to the COMM by first explaining the concept of a focus group, which is a small group of people with similar characteristics (such as mothers of infants) who are brought together to participate in a discussion about a chosen topic. The discussion is led by a moderator. Explain that the COMM will organise and lead FGDs in the community to find out whether community members are practising the behaviours in Tool 3b-3 and to identify problems and root causes of maternal and child health-related issues. Ask the COMM members what they think are some possible advantages and disadvantages of FGDs. You can then offer the points below as additions if they are not mentioned by the group.

FGDs are valuable because they:

- capture real-world perspectives on topics where data are limited
- generate diversity of information and participant interaction, triggering rich discussion of issues
- leverage the strong oral tradition that some cultures have
- foster mutual support, which may be an asset for participants.

However, there are some disadvantages of FGDs as well, including:

- Participants might respond based on what other people say.
- Participants might not offer different ideas when there is agreement in the group, even though they might have new or alternative ideas or opinions that could be valuable to discuss.
- Respect for elders in a group with members of different ages might keep younger participants from speaking openly.

2. Introduce the FGD Guide

The FGD Guide that will be used for this work is found in Tool 3b-5. This guide contains questions related to all of the indicators and behaviours found in Tool 3b-3. In most cases the COMM can use this FGD Guide, rather than creating its own.

Pass out one copy of Tool 3b-5 for every two participants. Look over the questions briefly. Point out that some questions ask the participants to think about the general situation in the community, while others ask about the participants' situations personally. This is intended to give a good mix of general and specific information. Also, point out that the questions are intentionally designed to allow for probing, to get beyond superficial information to deeper detail.

Working as a group – or perhaps divide the COMM members into two or three small groups – help them to go through the guide and select only those questions that relate to the indicators and behaviours they have chosen to study. They should choose 10 to 12 questions to include and cross out all others. Limiting the number of questions in the revised guide will ensure that there is enough time for in-depth discussion of each one within the given timeframe.

You will print out a revised version of the FGD Guide, keeping only those questions that the COMM has selected. Provide the revised guide to the COMM members as soon as possible.

3. FGD Techniques: Introductions and Informed Consent

Note the roles of the COMM members: Explain that each FGD should be carried out by at least three of the COMM members. The reason for having three people is so that one person can ask the questions, the second person can take notes, and the third person can be a careful observer and help with clarifications as needed.

Review the following steps and points with the COMM to emphasise that when the COMM organises an FGD, there are some ethical considerations that it must be kept in mind.

Informed leaders: In order to ensure that the community at large is comfortable with this method of collecting information, the COMM should consult traditional leaders and elders in the community before conducting the FGDs. The purpose of the FGDs should be made clear, and permission should be obtained to hold the discussions in the community.

Informed consent of participants: Explain to the COMM that before each FGD is held, a similar process, called informed consent, should be conducted with the proposed FGD participants. The purpose of informed consent is to be sure that all participants are voluntarily contributing to the FGD; those who do not want to participate are free to say no. The participants should understand the reason behind the FGD: the COMM wants to appreciate more about the community members' beliefs and practices, and find about more about the issues that affect them, so that the health of everyone can be improved. The participants are likely to be willing to participate for this reason. Once the FGD moderator shares this information with the group, each participant should provide his or her verbal consent to this understanding (say 'yes' or 'no' to understanding the FGD purpose and to voluntarily participating). In this process the following should be emphasised to the participants:

- The confidentiality of the discussion will be maintained and no names will be written down or used.
- All participants are encouraged to share.
- No person should dominate the discussion, allowing all who want to share to do so.
- There are no right or wrong answers.
- Focus group participants should respect one another's opinions.
- No person is required to stay in the FGD if he or she begins to feel uncomfortable or wishes to leave.

Role play: With your co-facilitators, role play the opening of an FGD. Introduce yourselves, share the reason you are holding the FGD, obtain the informed consents, and make sure all the points above are mentioned.

4. FGD Techniques: Questioning

It takes skill to carry out a good focus group discussion. The COMM member asking the questions must be alert and attentive to the answers that the participants are giving. The following points are important to keep in mind:

- Ask open-ended questions. Try to avoid asking 'yes or no' questions, which will give you bare facts, but they won't answer 'why'.
- Most questions should be followed up with additional probing questions. Probing questions help you to get deeper into the topic and understand more about it. The FGD Guide provides you with the probing questions you can ask.
- Make sure that you try to involve all of the participants. The discussion should not be dominated by one or two people. If that is happening, the interviewer may ask, 'Does anyone else have anything to add?', or select a quiet member and ask, 'What do *you* think about this?'
- Another way to elicit responses from all members is to be silent for a minute or two. With prolonged silence, pressure will build up to say something.
- Avoid making judgements about the responses. You must remain neutral throughout the FGD, even if you believe the participants are 'incorrect' in their knowledge or practices.
- Do not show that you think an answer is 'good'. You can maintain a neutral 'yes', 'OK', or 'mmm-hmm' to all answers.

Now look again at Tool 3b-5, Focus Group Discussion Guide. You will see that most of the questions have prompts for the types of information to probe for.

An exercise to practise probing questions: Have the participants work in pairs. One person should describe his or her family simply, using mostly facts. The partner then asks probing questions to learn more than the simple data provided. You and your co-facilitators may role play a short example of the exercise first.

Role play: Now you and your co-facilitators should carry out a 15 to 20 minute role play of a well-run FGD. Open the FGD with the informed consent and pointers listed previously. Then, choose two or three of the questions from the FGD Guide to ask those playing the role of community participants. You should show good techniques in asking probing questions, maintain a neutral stance throughout, and gather as much information as possible. Following the role play, debrief with the group members. What did they observe? Did they 'catch' you doing anything incorrectly? What was done well?

The important point is to make sure you spend enough time on this so that you feel confident that the COMM members will be able to question and probe effectively.

5. FGD Techniques: Group Management

Besides knowing how to ask effective questions during the FGDs, the COMM will need to have some skill in group management. Ask the participants why they think they will need this skill. Listen to their ideas, and then make the following points if they have not already been mentioned:

- Most groups display some power dynamics. Some group members may feel more special, have a higher social ranking, or be more knowledgeable than others. This this can create a negative environment in the group. The COMM should be alert and make sure that everyone has a chance to participate equally.
- Groups are usually made up of more talkative and less talkative people, but it is important to make sure that everyone is heard.
- Those who make up the most vulnerable usually have the least power and are very often reluctant to speak up in the presence of others. Yet it is *especially* the most vulnerable whom the COMM needs to hear! They will often have more serious health issues than others, and it is important for the COMM to hear about their situations.

Spend some time in discussion with the COMM members on these points. Brainstorm together how they can effectively manage focus groups that show some of these characteristics. You may have them practise role plays where, for example, the FGD leader must try to keep the dominant or powerful people from talking too much while also making sure that the quieter and more vulnerable are heard.

6. FGD Techniques: Note Taking

Tool 3b-3 is the form that the COMM will eventually complete based on the information from the FGDs. However, it is not a good idea to fill in the form during the FGD. First of all, the note taker might become so intent on the form that he or she misses important parts of the conversation. Second, the small spaces in the form require the note taker to summarise, which is not the goal at this stage. Rather, the COMM wants to capture as much information as possible during the FGDs, without summarising or interpreting. The COMM can summarise later.

Instead of filling in the form, the note taker will use a notebook and sticky notes (if sticky notes are not available, cut regular paper into squares). The note taker will write general information in the notebook. The note taker will write any barriers that come up on sticky notes.

The barriers should be written verbatim on the sticky note, thereby capturing the words and the meaning that the speaker intended. One sticky note can be used for each main point. The note taker can write the number of the question in the corner of the sticky note.

Practise this by distributing 7.5 x 12.5 cm sticky notes or pieces of cut paper to each person. You and your co-facilitators will simulate a FGD, going through one or two questions from the interview guide. The participants will practise listening for barriers and writing them one by one on individual sticky notes. When you have finished, collect all the notes. Organise them by question, and then organise them further by similar answers or themes. This is a preview of the analysis the group will do in Step 5. The important point now, though, is to practise with the note taking itself.

7. Practise with the Interview Guide: In the Classroom

Distribute copies of the **revised** FGD Guide (the one you printed after removing the questions they crossed out). First, go through the guide with the whole group, deciding together how the questions should be asked and how the probing should occur.

Then have the COMM members work in small groups and practise carrying out an FGD. One person will ask the questions, one will observe, and a third will do the note taking on sticky notes. Three or four others will play the role of FGD participants. Pair up illiterate members with literate members, if applicable, and make sure that illiterate members are participating and not just observing.

Ideally, there should be one facilitator assigned to work with each group. The facilitator should observe as the group practises and mentor it throughout the process. Provide feedback as needed. Check that the members are not asking leading or judgemental questions (such as, 'You *do* sleep under a mosquito net, *right?*'), that they are accepting of all answers, writing down important comments, and so on. Make sure that by the end of the questioning they have gathered the information they need. Also ensure that note taking is done properly, by recording general information in the notebook and barriers on the sticky notes. Emphasise that notes should always be kept secure in order to ensure confidentiality.

Note: You should spend as much time as necessary on this practise. It might take as long as a complete morning or a complete afternoon, with participants alternating roles so that everyone has a chance to practise different roles. It will take time for the COMM members to master these techniques.

8. Practise with the Interview Guide: In the Community

Now you will organise some volunteers from the community who will be willing to help the COMM practise the FGD. The COMM will divide into teams of three or four (leader, note taker and one or two observers). Each team should carry out the complete FGD with three to five community members. You will need to organise this. You can expect the exercise to take about two hours. The facilitators should assist the groups as necessary.

Note: Even though you will spend time now practising these skills, it is important that you try to accompany COMM members the first few times they carry out FGDs so that you can supervise and mentor them. This is not a skill that is perfected immediately; it requires ongoing practise and feedback.

ACTIVITY 6: PREPARING TO CARRY OUT FGDS

1. The Focus Groups: Who and How Many

The COMM should conduct FGDs with groups of 6 to 12 people. Who will these people be? At a minimum, they should carry out FGDs with the groups listed in Table 1. These should all be separate groups (there should be no men or CHWs with the pregnant women and caregivers, no CHWs with men or male partners, and so on). Separating the groups is important, because it helps to ensure that the participants do not feel reserved when sharing; they will interact with their peer group members only, not with potential influencers.

Also, it is important to ensure that FGDs are held with groups representing the most vulnerable groups in the community in order to gain their views and insights. If the COMM is not sure who the most vulnerable are, you may 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 FGDs.

- 'How Does it Feel to be a Vulnerable Child?' in Tool 3b-6
- 'Who Are the Vulnerable Families in our Area?' in Tool 3b-7
- 'Where Are the Most Vulnerable?' in Tool 3b-8

It is generally recommended that the COMM carry out four FGDs for each of the target groups identified, for a total of 20 FGDs. Remember that each FGD will be carried out by three COMM members. This means that the COMM will split up to carry out these FGDs – not all members will be present at every one. This will ease the burden and make it manageable to complete the number of FGDs required.

Write the information in Table 1 on a flipchart and review it with the COMM.

Table 1: FGD Groups

	Target Groups	Number of FGDs
A	Pregnant women and caregivers of children under 2: general population	4
B	Pregnant women and caregivers of children under 2: most vulnerable	4
C	Men who are partners of pregnant women and caregivers of children under 2	4
D	Adolescent girls	4
E	CHWs	4
	Total	**20**

2. The Focus Groups: Where

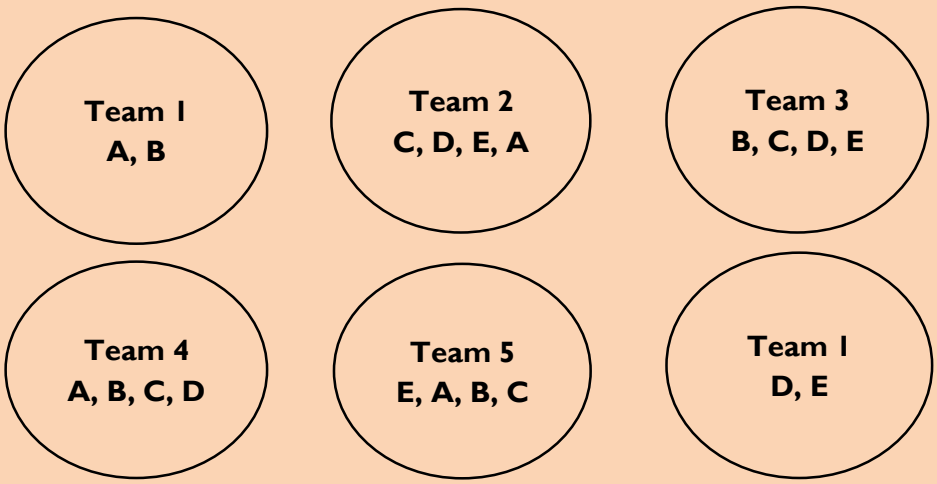
It is likely that the COMM covers an area that comprises more than one community. Thus the 20 FGDs will be dispersed throughout the communities. Again, this will happen by having the COMM members split up to complete this work.

- For example, if there are four communities, one FGD with each of the five target groups will be carried out in each community.
- If there are six communities, the COMM could organise itself as shown in Figure 1 below.

Figure 1: Diagram of FGD Locations

This diagram represents one COMM with fifteen members, covering six communities. The members will divide into five teams of three people each (one interviewer, one note taker and one observer). The circles represent the six communities. The letters represent which FGD is being done:

A = Pregnant women and caregivers of children under 2: general population
B = Pregnant women and caregivers of children under 2: most vulnerable
C = Men who are partners of pregnant women and caregivers of children under 2
D = Adolescent girls
E = CHWs



This diagram shows us that it is possible to complete the 20 recommended FGDs by splitting the COMM members into teams of three and going to the six communities covered by the COMM. Not every category of FGD will be carried out in every community, but that is acceptable.

With all the communities covered and 20 FGDs carried out across the area, the COMM has a good representative sample, ensuring that the answers given are an accurate reflection of the health issues for the population of the area.

Note: Although the recommendation is that the COMM carry out 20 FGDs, the members may reach a point where they feel that they have collected so much information that it will be difficult to analyse it all. If this happens, they

should stop before completing the 20 FGDs and analyse what they have. They can then decide if they want to complete the 20 or not. They should not stop, however, before reaching each one of the five groups in the box at least once.

Hold the FGDs in a safe and neutral place, such as a community centre or another location familiar and convenient to the participants. Special considerations should be made to ensure that the most vulnerable members of the community are represented and that the location is safe and neutral for them.

Be sure to schedule the FGDs for a time that is convenient for the participants. Arrange for some level of comfort and privacy (such as a separate or quiet room in the building or a space under a shaded tree outside the building). FGDs should last approximately 1 to 2 hours.

3. Discuss and Agree on Logistics

Now that you have reviewed 'who', 'how many' and 'where', the COMM should come up with a plan for completing the FGDs. At the end of this session it will fill in its Action Plan. For now, discuss with the COMM so that agreement can be reached on the arrangements that will be made.

ACTIVITY 7: KNOWLEDGE ASSESSMENT FOR SESSION 3B, STEP 3

As you close Step 3, ask the COMM to respond to each of the following statements as either 'true' or 'false' in order to assess the members' general understanding of the material. Allow the group time to discuss and agree on a collective response to each before it answers. If the group answers incorrectly, you will know that you need to revisit this information with the group before proceeding to the next session.

1. There is only one reason for conducting FGDs: to find out more about the behaviours that underlie the indicators of highest concern. (*Answer: FALSE*)

2. Obtaining informed consent from all participants before holding the FGDs is an essential step because it ensures that they understand the purpose behind the discussion and that their participation is voluntary. (*Answer: TRUE*)

3. Although preferable to separate the groups of women, girls, men, CHWs, and others for the FGDs, doing so is not necessary if it becomes too complicated to arrange. (*Answer: FALSE*)

STEP 4: TRAIN THE COMM TO LEARN FROM KEY STAKEHOLDERS

Notes for the Facilitator

In Step 3 the COMM learned how to carry out FGDs with pregnant women, caregivers of children under 2, male partners, adolescent girls, and most vulnerable groups. From these discussions the COMM will learn about the key health issues in the community from the point of view of these groups, the extent to which these groups practise healthy behaviours, and the barriers that may prevent them from doing so.

There may be other key stakeholders, however, who can contribute to the COMM's understanding of the local health situation, and other tools and methods the COMM may use. These will be reviewed in this step.

OPTIONAL ACTIVITY A: PREPARING TO CARRY OUT OTHER KEY INFORMANT INTERVIEWS

It is good for the COMM to use more than one method to gather the information it needs. A second method is through interviews with key informants. Key informants are those who may have a unique or specialist knowledge or point of view about the health situation, such as faith leaders, political leaders, others mentioned during the FGDs, or other people the COMM members identify as useful sources of information. Ask the COMM members to suggest some people that might be good key informants; they can simply mention titles like midwives, church and faith leaders, and CHW supervisors. Topics covered will depend on the indicators. Take some time to help the COMM decide who it might want to interview.

Next, review the FGD Guide with the COMM members and have them extract only those questions that they will use with the key informants. They may decide to include some additional questions. Type the revised version and provide it to the COMM members as soon as possible. If they decide to carry out key informant interviews, add the activity to the Action Plan at the end of this step.

OPTIONAL ACTIVITY B: EXISTING BARRIER ANALYSES REPORTS

It may be possible that your organisation or other partners in the area have carried out a formal barrier analysis of the health practices in the community. If this secondary data is available, you should share it with the COMM to add it to the information it is collecting. Alternatively, you could have a project or partner staff member come to the training to give a presentation of the data.

OPTIONAL ACTIVITY C: LEARNING FROM OTHER ORGANISATIONS AND PARTNERS

Find out what other health-focused groups and organisations are doing to identify and address barriers. Perhaps the COMM will benefit from meeting to learn from them or partnering with them to support each other's efforts.

OPTIONAL ACTIVITY D: COMMUNITY MAPPING

A community map can be useful for showing the catchment area and the resources that are available in it. Remember that whenever we refer to the community, we must be sure to consider all segments of society. This activity can be used to explore who the most vulnerable are and where they live. The COMM will make the community map with input from community members, following the steps below.

1. Draw a map of the community. This can be done on the ground with the border represented by items such as sticks or stones, or on flipchart paper with markers.
2. Add resources to the map that are useful for promoting good health as well as elements that cause health problems. Examples may include:
    - health centres, churches and mosques, and schools
    - homes of CHWs, skilled birth attendants or traditional healers
    - water sources or fresh farmers' markets.
3. Indicate some of the more vulnerable families to target them for assistance.
4. Ask the community to add other resources and elements to the map.
5. Add external partners that help the community outside the borders on the map.

STEP 5: 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 3b-9, COMM Action Planning and Monitoring Tool: Root-Cause Analysis (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 action the COMM will take. This is the form for the root-cause analysis. It the COMM is involved in other activities they will receive other forms for tracking community health status, supporting CHWs, and so on.
- Each category has one or more goals. Ask the group to read aloud the goal of the root-cause analysis. The goal also can 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.
- 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.
- Review the columns and explain each one.

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

Now that the COMM has decided what it needs to do to carry out the FGDs and any key informant interviews (KIIs) the group agreed on, it can begin to complete this form to help it organise the implementation of these activities.

Draw the first five columns (activity, who, resources and planned date) on flipchart paper. Ask the COMM what it needs to do first, before beginning the FGDs. 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 activity, write who will carry it out, what resources might be needed and the planned date to complete the activity. 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 3b-9 and then complete the rest of it. Have the members decided how they will split up to complete the 20 FGDs, and who will go where? It is best to list all 20 FGDs on the Action Plan so that the group is clear about the schedule. The secretary of the COMM should complete the table for the activities the COMM will need to carry out in order to complete the root-cause analysis.

Explain that the COMM will keep track of their progress against these activities using the remaining columns of the form. The COMM is encouraged to meet monthly and review the Action Plan at every meeting.

STEP 6: ANALYSING THE INFORMATION

Note: You will only carry out this phase of the session when the COMM has completed the FGDs, KIIs and any other methods the COMM has decided to use to collect information about the community. You will need to provide the COMM with some 10x15cm cards and some different coloured stickers.

ACTIVITY 1: EMPHASISE CONFIDENTIALITY

Have a discussion with the COMM about the importance of maintaining the confidentiality of the information it has gathered; highlight the need to protect community members' privacy. Point out that any known personal identifiers (names, places of residence, specific affiliations, and so on) should not be revealed when the information is shared among the COMM members or the community at large. The data should always be handled as numbers and statistics, not names. As the COMM members are sharing information, they should not give the names of the participants in the FGDs.

ACTIVITY 2: CONSOLIDATE THE INFORMATION AND WRITE ON CARDS

Now the COMM needs to study the information from the FGDs, KIIs and any other methods it used, and identify the health issues that came up most frequently during the information collection process.

- To begin, have the COMM write every behaviour that it decided to include in the FGD and KII Guides on an individual card. For example, it may have focused on the following behaviours during the FGDs and KIIs: 'exclusive breastfeeding', 'antenatal care visits', 'handwashing with soap', and so on. There should be a separate card for each behaviour.
- Based on all of the information the FGDs have gathered, they should try to determine which behaviours are practised the most and which are practised the least in their area. The members can place the cards in sequence, from those behaviours practised the most to those practised the least, laying them down vertically on one side of the paper.
- Have the COMM members read through and discuss all of the notes collected from the FGDs and KIIs. They should go question by question through their FGD and KII Guides and allow everyone to share what they found out about the practise of the behaviour and the potential barriers to it. This will be a large amount of information, so this step will take some time.
- As they are reviewing the information, have them write the barriers that they are identifying on separate cards. They will write each barrier or issue on an individual card and place them next to the behaviour(s) to which they correspond. One behaviour might have a number of barriers.
- **Note:** See Figure 2, which shows cards lined up with the barriers next to the behaviours to which they correspond. Help the COMM to create a similar display.

ACTIVITY 3: WHO CAN RESPOND TO THE BARRIERS?

- Now the COMM will look at the list of barriers and decide if they can be addressed in the household by CHWs. Choose a colour to represent CHWs, and have the COMM place a sticker of that colour on every barrier that can be addressed by CHWs.
- For those barriers that cannot be easily addressed at household level, the COMM should decide if there are actions they can take as a community group to address them. If so, place stickers of a different colour, representing the COMM, on each of those barriers.
- There may be some instances when the issue or barrier will need to be elevated to another level – perhaps by asking assistance of an NGO, or involving the faith community to address some harmful beliefs, or undertaking advocacy efforts with the clinic or the government. A different colour will be assigned to these and stickers placed on the corresponding cards.

At this point the COMM will have identified those barriers towards which the COMM can take action. The exercise will show the COMM members that they do not have to do everything; indeed, much of the work of sensitising and counselling, for example, is better left to the CHWs.

In Figure 2, the barriers with yellow stickers are the ones that CHWs can address when making visits to the family. The ones with blue stickers are ones that the COMM will handle. Sometimes the COMM will reinforce the work

and the messages of the CHWs, as in the examples with both blue and yellow stickers, while at other times the barrier can be addressed only at the level of the COMM.

Note: At the end of this activity you should help the COMM to create a final product, similar to Figure 2, by attaching the cards to flipchart paper for permanent reference and perhaps posting the illustration on the wall. Individuals should copy the information into their notebooks during one of the breaks.

Figure 2: Behaviours and Barriers

ACTIVITY 4: PRIORITISING TASKS

Through this in-depth analysis of the information the COMM may have identified a long list of behaviours, issues and barriers that require its responsive action. To manage the tasks that lie ahead, the COMM needs to choose a manageable number of actions to prioritise.

Note: It is appropriate for the facilitator or other technical experts to assist the COMM in this prioritisation, as the specialists will have a strong understanding of the various practices and challenges.

Share the following criteria[2] with the COMM to consider when it is establishing its priorities:

- Severity: Is this issue life threatening? Does it lead to chronic life complications?
- Frequency: How many people experience the issue? How often?
- Future risk: How many people could experience this issue in the future, especially if it is not addressed?
- Impact on the community: What is the impact that this issue has on our community now?
- Feasibility of response: Have any effective responses to the issue been identified? Is financial, material and resource support available? Do people in the community possess the necessary skills and abilities?

[2] L. Howard-Grabman and G. Snetro, 'How to Mobilise Communities for Health and Social Change,' Health Communication Partnership/USAID (2003).

You may help the COMM to prioritise in whatever way you judge best. The COMM may select three barriers to begin with, for example. The COMM may make its decision as a group or vote by placing beans, pebbles or stickers on the cards.

ACTIVITY 5: COMPLETE TOOL 3B-3: COMMUNITY DATA FORM AND TOOL 3B-4: LOCAL HEALTH FACILITY INTERVIEW GUIDE

While the FGDs were being carried out, the COMM members were instructed to use notebooks and sticky notes rather than trying to condense the information on their forms. Now that they have completed the analysis, however, they should try to summarise their learnings on these two tools. Take some time to do this now, and assist the group as needed.

Finally, wrap up by explaining that the Session 4 will help the COMM to determine how to respond to the issues and barriers it has identified, and also to develop an Action Plan for doing so.

ACTIVITY 6: KNOWLEDGE ASSESSMENT FOR SESSION 3B, STEP 6

As you close Step 6 of Session 3b, ask the COMM to respond to each of the following statements as either 'true' or 'false' in order to assess the members' general understanding of the material. Allow the group time to discuss and agree on a collective response to each before it answers. If the group answers incorrectly, you will know that you need to revisit this information with the group before proceeding to the next session.

1. Using participants' personal information during COMM discussions and analysis is acceptable as long as this information is not shared with other community members. *(Answer: FALSE)*

2. The analysis process should separate out, yet establish links among, the most common barriers and behaviours, using the information collected. *(Answer: TRUE)*

3. Identify as many problematic barriers and issues as possible for the COMM to respond to, regardless of scope or level of priority, in order for the COMM to have the greatest effect. *(Answer: FALSE)*

STEP 7: DEBRIEF WITH THE COMMUNITY

The COMM can learn about debriefing meetings in Session 6. Remind the members now, however, that they should plan to hold an extraordinary debriefing meeting when they have finished the root-cause analysis in order to present the results to all stakeholders. They also will learn in Session 6 how to present statistics and information.

TOOL 3B-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%		

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 two weeks for births in the three years proceeding 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 3B-2. ICONS (FOR PRESENTING KEY INDICATORS AND NATIONAL HEALTH STATISTICS)

Figure	General and Mortality Indicators
	Under-5 ranking – N/A
	Under-5 mortality rate (U5MR): per 1,000 live births
	Infant mortality rate (IMR): per 1,000 live births
	Neonatal mortality rate (NMR): per 1,000 live births
	Maternal mortality ratio (MMR): per 100,000 live births
Figure	**Nutrition Status**
	Newborn low birth weight (LBW) – % of newborns with low birth weight (<2500 grams)
	Height/length for age(HFA) (Stunting) – % of children 0–59 months stunted (HAZ < -2) CWB)
	Weight for height (WFH) (Wasting) – % of children 0–59 months wasted (acute undernutrition) (WHZ < -2)
	Weight for age(WFA) (Underweight) – % of children 0–59 months underweight (WAZ <-2)
	% of infants under 6 months who are exclusively breastfed
	Early initiation of breastfeeding
Figure	**Micronutrients**
	% of children 6–59 months with anaemia (Hb<11g/dL)
	% of women of reproductive age (15–49 years) with anaemia (Hb<12g/dl for non-pregnant; Hb<11g/dl for pregnant women)
	% of children 6–59 months who received a high dose of vitamin A supplement (VAC)
	% of households with access to iodised salt (can serve as proxy for prevalence of goitre)
Figure	**Maternal and Reproductive Health**
	% of women age 20–24 who were first married/in union before age 18
	% of women age 15–49 years attended antenatal clinic at least four times during pregnancy
	% of births attended by skilled birth attendant
	% of women receiving postnatal care within two days of delivery
	National availability of emergency obstetric care services (% of recommended minimum)

TOOL 3B-3. COMMUNITY DATA FORM

	Desired Behaviours	Part 1 Local Statistics Facilitator provides	Part 2 Local Level: Health Facility Clinic staff give information and views ('most', 'many', 'some', 'few', etc.)	Part 3 Local Level: Focus Group Discussions The general situation of the practice in the area from FGDs or interviews ('most', 'many', 'some', 'few', etc.)	Percentages (from CHW data) Q1	Q2	Q3	Q4	Comments from FGDs or Other Sources of Information. Successes, Gaps and Barriers
		BASELINE: ROOT-CAUSE ANALYSIS			MONITORING				
	**Pregnant Women: Adequate Diet**								
1	Pregnant women take one additional meal and an extra nutritious snack each day								
2	Families use iodised salt								
	**Pregnant Women: Iron Folate and De-worming**								
3	Pregnant women take iron-folate tablets every day for at least six months during pregnancy								
4	Pregnant women consume locally available, iron-rich foods such as fish, red meat, green leafy vegetables								
5	Pregnant women seek and take deworming tablets								
6	Pregnant women wear shoes								

(Tool 3b-3 continued)		Part 1	Part 2	Part 3					
	Desired Behaviours	**Local Statistics**	**Local Level: Health Facility**	**Local Level: Focus Group Discussions**	**Percentages (from CHW data)**				**Comments from FGDs or Other Sources of Information. Successes, Gaps and Barriers**
		Facilitator provides	Clinic staff give information and views ('most', 'many', 'some', 'few', etc.)	The general situation of the practice in the area from FGDs or interviews ('most', 'many', 'some', 'few', etc.)	**Q1**	**Q2**	**Q3**	**Q4**	
		BASELINE: ROOT-CAUSE ANALYSIS			**MONITORING**				
	**Pregnant Women: Tetanus Toxoid**								
7	Pregnant women go for their tetanus toxoid injections								
	**Pregnant Women: Malaria**								
8	Pregnant women sleep under a specially treated bed net every night								
9	Pregnant women receive two or more doses of malaria prevention at the health clinic during their pregnancy								
10	Pregnant women with malaria are treated with correct drugs/medication								
	**Pregnant Women: Birth Preparation**								
11	Pregnant women work less, rest more								
12	Households prepare for birth with clean supplies at home for mother and infant; transportation is pre-arranged								
13	Families are prepared to go quickly to a facility if the woman experiences a danger sign or complication								

	(Tool 3b-3 continued)	Part 1	Part 2	Part 3					
	Desired Behaviours	**Local Statistics**	**Local Level: Health Facility**	**Local Level: Focus Group Discussions**	**Percentages (from CHW data)**				**Comments from FGDs or Other Sources of Information. Successes, Gaps and Barriers**
		Facilitator provides	Clinic staff give information and views ('most', 'many', 'some', 'few', etc.)	The general situation of the practice in the area from FGDs or interviews ('most', 'many', 'some', 'few', etc.)	**Q1**	**Q2**	**Q3**	**Q4**	
		BASELINE: ROOT-CAUSE ANALYSIS			**MONITORING**				
14	Husbands and families have access to financial resources for expenses related to the delivery								
15	Women avoid smoking, alcohol and illicit drugs during pregnancy								
	Pregnant Women: Healthy Timing and Spacing of Pregnancies								
16	Couples know about the health risks and benefits of using a family planning method								
17	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								
18	Pregnant women seek/demand antenatal care (ANC) services								
19	Husband/partner or other family member accompanies pregnant women to ANC visits								
20	Pregnant women choose to get HIV testing and deliver at a facility								

	(Tool 3b-3 continued)	Part 1	Part 2	Part 3					
	Desired Behaviours	**Local Statistics**	**Local Level: Health Facility**	**Local Level: Focus Group Discussions**	**Percentages (from CHW data)**				**Comments from FGDs or Other Sources of Information. Successes, Gaps and Barriers**
		Facilitator provides	Clinic staff give information and views ('most', 'many', 'some', 'few', etc.)	The general situation of the practice in the area from FGDs or interviews ('most', 'many', 'some', 'few', etc.)	**Q1**	**Q2**	**Q3**	**Q4**	
		BASELINE: ROOT-CAUSE ANALYSIS			**MONITORING**				
21	TB+ pregnant women register with Directly Observed Treatment Short Course Strategy (DOTS) and follow treatment, completing the drug regime								
	Pregnant Women: Health Services – Skilled Birth Attendant								
22	Pregnant women and their family consider it a priority to give birth at a health facility								
	Pregnant Women: Health Services – Postnatal Care								
23	Women go to health facility for postnatal care for themselves and their newborn babies								
	Children Under 2: Essential Newborn Care								
24	Mothers practise cleaning of eye and cord care								
25	Mothers put baby to breast, wrap and cuddle skin to skin								
	Children Under 2: Appropriate Breastfeeding								
26	Mothers feed the baby exclusively breast milk until baby reaches 6 months of age								

	(Tool 3b-3 continued)	**Part 1**	**Part 2**	**Part 3**					
	Desired Behaviours	**Local Statistics**	**Local Level: Health Facility**	**Local Level: Focus Group Discussions**	**Percentages (from CHW data)**				**Comments from FGDs or Other Sources of Information. Successes, Gaps and Barriers**
		Facilitator provides	Clinic staff give information and views ('most', 'many', 'some', 'few', etc.)	The general situation of the practice in the area from FGDs or interviews ('most', 'many', 'some', 'few', etc.)	**Q1**	**Q2**	**Q3**	**Q4**	
		BASELINE: ROOT-CAUSE ANALYSIS			**MONITORING**				
27	Mothers continue to breastfeed their child for up to 24 months								
28	Mothers continue and increase breastfeeding during child's illnesses								
29	Mothers breastfeed on demand								
30	Mothers give the colostrum to their babies								
31	Mothers give no liquids or other foods before breast milk is offered								
32	Caregivers do not give the child any bottles								
	**Children Under 2: Handwashing with Soap**								
33	Families understand the importance of toileting facilities and use them								
34	Families understand the importance of keeping a clean handwashing station with an effective product (soap, lime/lemon or ash) in or near the house and use it								
35	Caregivers wash hands with soap before cooking, eating and feeding baby and after toilet and disposal of faeces								

(Tool 3b-3 continued)		Part 1	Part 2	Part 3					
	Desired Behaviours	**Local Statistics**	**Local Level: Health Facility**	**Local Level: Focus Group Discussions**	**Percentages (from CHW data)**				**Comments from FGDs or Other Sources of Information. Successes, Gaps and Barriers**
		Facilitator provides	Clinic staff give information and views ('most', 'many', 'some', 'few', etc.)	The general situation of the practice in the area from FGDs or interviews ('most', 'many', 'some', 'few', etc.)	**Q1**	**Q2**	**Q3**	**Q4**	
		BASELINE: ROOT-CAUSE ANALYSIS			**MONITORING**				
	Children Under 2: Appropriate Complementary Feeding								
36	Caregivers provide variety of food that includes animal-source foods using responsive feeding techniques								
37	Caregivers understand the function of the growth card and take child to growth monitoring every month until immunisations are completed, then every two to three months								
	Children Under 2: Adequate Iron, Anaemia								
38	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								
39	Caregivers give vitamin A-rich foods to their children, including fruits or vegetables (yellow or orange in colour) and animal-source foods								

	(Tool 3b-3 continued)	Part 1	Part 2	Part 3					
	Desired Behaviours	**Local Statistics**	**Local Level: Health Facility**	**Local Level: Focus Group Discussions**	**Percentages (from CHW data)**				**Comments from FGDs or Other Sources of Information. Successes, Gaps and Barriers**
		Facilitator provides	Clinic staff give information and views ('most', 'many', 'some', 'few', etc.)	The general situation of the practice in the area from FGDs or interviews ('most', 'many', 'some', 'few', etc.)	**Q1**	**Q2**	**Q3**	**Q4**	
		BASELINE: ROOT-CAUSE ANALYSIS			**MONITORING**				
40	Caregivers seek vitamin A capsules for children 6–59 months old								
	**Children under 2: Oral Rehydration Therapy (ORT) and Zinc**								
41	Caregivers understand that children with diarrhoea need more fluid and for children under six months, this is breast milk only								
42	Caregivers practise threefold oral rehydration therapy (ORT) approach: oral rehydration solution (ORS); zinc; continued breastfeeding and complementary foods, if appropriate								
43	Caregivers recognise the signs of severe dehydration and take the child to a healthcare facility for skilled care								
44	Caregivers know definition of diarrhoea and signs of dehydration (three or more liquid stools per day)								

(Tool 3b-3 continued)		Part 1	Part 2	Part 3					
	Desired Behaviours	Local Statistics	Local Level: Health Facility	Local Level: Focus Group Discussions	Percentages (from CHW data)				Comments from FGDs or Other Sources of Information. Successes, Gaps and Barriers
		Facilitator provides	Clinic staff give information and views ('most', 'many', 'some', 'few', etc.)	The general situation of the practice in the area from FGDs or interviews ('most', 'many', 'some', 'few', etc.)	Q1	Q2	Q3	Q4	
		BASELINE: ROOT-CAUSE ANALYSIS			MONITORING				
	Children Under 2: Malaria								
45	Caregivers recognise the danger signs of malaria and take child to the health facility								
46	When child is given antimalarials, caregivers ensure that child takes medication promptly								
47	Caregivers keep children under bed nets (LLINs) every night								
	Children Under 2: Full Immunisation for Age and De-worming								
48	Caregivers seek immunisations at health facility								
49	Caregivers ensure that the child's health card is updated after each visit to the clinic and keep the card safe								
50	Caregivers ensure child receives de-worming medication starting at 12 months of age								
51	Caregivers ensure that when child begins to walk, he or she wears shoes								

(Tool 3b-3 continued)		Part 1	Part 2	Part 3					
	Desired Behaviours	Local Statistics	Local Level: Health Facility	Local Level: Focus Group Discussions	Percentages (from CHW data)				Comments from FGDs or Other Sources of Information. Successes, Gaps and Barriers
		Facilitator provides	Clinic staff give information and views ('most', 'many', 'some', 'few', etc.)	The general situation of the practice in the area from FGDs or interviews ('most', 'many', 'some', 'few', etc.)	Q1	Q2	Q3	Q4	
		BASELINE: ROOT-CAUSE ANALYSIS			MONITORING				
	Children Under 2: Acute Respiratory Infection								
52	Caregivers recognise the danger signs of pneumonia and take child to health facility								
53	Caregivers seek treatment for pneumonia in children and complete the full course of medication								
	Children Under 2: Paediatric HIV and TB								
54	Infants born to HIV+ mothers are tested 4-6 weeks after delivery and receive appropriate care (PMTCT)								
55	Caregivers recognise the importance of infants born to HIV-positive mothers getting specialised PMTCT services								
56	Family members understand the correct ways to prevent mother-to-child transmission of HIV								
	Children Under 2: Birth Registration								
57	Caregivers register the infant's birth during the first month of life								

TOOL 3B-4. 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 3b-4 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 3b-4 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 3b-4 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? (Such as 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: _____

TOOL 3B-5. FOCUS GROUP DISCUSSION GUIDE

Focus Group Discussion with Pregnant Women and Caregivers of Children Under 2

Informed Consent

- Explain the reason for the FGD as follows: 'We want to appreciate more about the community members' beliefs and practices, and find out more about the issues that affect you, so that the health of everyone can be improved.'
- Ask each person if he or she voluntarily agrees to participate.

Procedures and Information

- The confidentiality of the discussion will be maintained and no names will be written down or used.
- All participants are encouraged to share.
- There are no wrong answers.
- No one person should dominate the discussion; allow all who want to share to do so.
- No person is required to stay in the discussion if he or she begins to feel uncomfortable or wishes to leave.
- The COMM will make the results known – without mentioning any names or other identifying information – during a special community meeting that it will call.

`Part One – Pregnancy

No.	Questions
Section 1: Adequate Diet	
1.1	What do women in this community normally eat on a daily (or weekly) basis? *Listen/probe for:* • Iron rich foods, animal source protein, vitamin A-rich foods • Iodised salt (versus non-iodised) availability • Amount, frequency • Inequalities or differences between what men/others eat
1.2	What are some of the changes to this diet that women make when they are pregnant? *Listen/probe for:* • iron rich foods, animal source protein, vitamin A-rich foods • iodised salt (versus non-iodised) • eating less/more/the same than usual • foods that women should not eat during pregnancy • reasons behind these changes
1.3	*(Ask only pregnant participants):* Can you describe what you ate yesterday? *Listen/probe for:* • whether it felt like enough food • how these foods or amounts of food made them feel physically • other/additional foods that they felt like eating but could not • potential barriers to eating what they consider to be 'well' during pregnancy
Section 1: Adequate Diet while Pregnant – Digging Deeper	
1.4	What are the main crops (grains/cereals, vegetables and fruit) grown in this area? *Listen/probe for:* • whether their own families grow these foods • whether they eat these foods regularly (as opposed to selling them for income) • reasons behind their answers

(Tool 3b-5 continued)

1.5	How are the crop harvests, generally? How are they this year? *Listen/probe for:* • reasons for why the harvests have been this way • consequences for theirs and their children's diets
1.6	How common is it for families to buy food in addition to what they grow? *Listen/probe for:* • how often they buy these foods • what other/additional types of foods they buy • any additional types of foods they would like to access, but cannot • reasons behind buying these foods
Section 2: Iron-Folate and De-worming	
2.1	How common is it for women to consume iron-folate supplements, especially when pregnant? *Listen/probe for:* • perceptions around the consumption (e.g., importance for health and nutrition of mom and baby) • where women access iron-folate • reasons why they do – or do not – access (e.g., influencers/decision-makers, distribution issues) • side effects of taking iron-folate supplements for women (physical and/or socio-economic)
2.2	Please describe the consumption of iron-rich foods on a regular basis, by women if reproductive age and especially by pregnant women. *Listen/probe for:* • specific foods – leafy green vegetables and animal-source proteins • local availability of these foods (e.g., grown at home, available and/or affordable at the local market, etc.) • cooking methods and/or cultural practices related to consumption (e.g., increase or decrease during pregnancy, beliefs around why they are/are not good for pregnant women to eat, etc.)
2.3	How common is it for pregnant women to receive and take de-worming medication? *Listen/probe for:* • where women get the medication • reasons why they do or do not take the medication (e.g., influencers/ decision makers, side effects, beliefs)
2.4	How common is it for women to wear shoes at all times? *Listen/probe for:* • reasons why women may not wear shoes • perception around why it is important to wear shoes – how does this contribute to better health, and what kinds of health problems are prevented by wearing shoes?
Section 3: Tetanus Toxoid (TT)	
3.1	How common is it for pregnant women to receive TT immunisation during pregnancy? *Listen/probe for:* • perceptions around TT immunisation (e.g., importance for health and nutrition of mom and baby) • how many doses are normally received • for pregnant women only: if they received some/all doses during this and/or previous pregnancy • where women access the immunisations • reasons why they do – or do not – access (e.g., influencers/decision-makers, distribution issues) • side effects of receiving immunisations (physical and/or socio-economic)
Section 4: Malaria (In areas with malaria incidence only)	
4.1	Use **beans** to have the participants show the percentage of pregnant women in the community that they think sleep under a bed net on a regular basis

(Tool 3b-5 continued)

4.2	Please describe the use of bed nets by families in this community, especially pregnant women. *Listen/probe for:* • how regularly they sleep under the nets (e.g. nightly practice, or something done only occasionally) • reasons why they do or do not sleep under the nets (e.g. specific factors that may prevent or facilitate the practice) • where these bed nets are received or purchased • whether the nets are specially treated • what they may do as an alternative to prevent malaria
Section 5: Birth Preparation	
5.1	What types of changes do pregnant women usually make to their lifestyle or daily routine? *Listen/probe for:* • working less/more/the same than usual • resting less/more/the same than usual • behavioural choices such as smoking and use of alcohol or other drugs • differences in stages of pregnancy • reasons behind making these changes • opinions around whether these changes are appropriate
5.2	What kind of special help do others provide to women when they are pregnant? *Listen/probe for:* • the roles of men/husbands in particular • the roles of other family members, neighbours or older children • reasons behind these (especially potential barriers) • beliefs about the importance of this special help
5.3	What conditions do families consider important to be adequately prepared for safe and healthy childbirth? *Listen/probe for:* • involvement of/guidance from a skilled provider • agreed upon birthing and emergency plans • supplies – hygiene and cleaning (soap for handwashing, and clean /sterile water, towels, eye and cord care, etc.) and/or any medications (antibiotics, ARVs, etc.) • emergency transportation mechanism • safe and clean birth recovery environment (eg, mosquito net, appropriate temperature, etc.)
5.4	What financial resources are needed in order to be fully prepared for safe and healthy childbirth? *Listen/probe for:* • facility and/or skilled provider fees • transportation to/from health facility • supplies and materials for mother and infant • necessary medications (emergency and non-emergency) • decision-making around financial resource use • barriers to accessing the necessary financial resources
5.5	What are some of the signs that women may have a problem with their pregnancy or delivery? (example: bleeding) *Listen/probe for:* • how they know these things are signs of a problem • consequences resulting from these signs (for both mother and baby) • possible causes of these signs of problems (give examples if needed to probe)

(Tool 3b-5 continued)

5.6	How do pregnant women usually respond when they experience these types of problems? *Listen/probe for:* • care-seeking practices – both at home and at facility, skilled provider, emergency care • involvement of husband/partner or other family members in responding • beliefs about these responses – if they are appropriate, how important they are for the health of mom and baby, etc. • potential barriers to responding in the way they believe is most appropriate
Section 6: Healthy Timing and Spacing of Pregnancy	
6.1	After giving birth, how long do women usually wait before getting pregnant again? *Listen/probe for:* • number of months and/or years • factors influencing how long they wait – maternal age, health, finances, # and gender of other children, etc. • risks to waiting shorter and/or longer amounts of time between pregnancies • benefits to waiting shorter and/or longer amounts of time between pregnancies
6.2	If a woman in this community does not want to become pregnant, what does she do to avoid pregnancy? *Listen/probe for:* • family planning methods available – contraceptives, lactational amenorrhea, abstinence, etc. • accessibility – how and when • acceptability – women's preferences for family planning methods • effectiveness – how well these methods work
6.3	How do men in this area generally feel about contraception and family planning? *Listen/probe for:* • the reasons behind their beliefs • particular methods acceptable/not acceptable • husbands and wives ability to discuss family planning openly
6.4	Use **beans** to have the participants show the percentage of women in the community that they think: • want to avoid becoming pregnant, and are using a form of family planning effectively • want to avoid becoming pregnant, but are not using any form of family planning method *Listen/probe for during discussion:* • the reasons that women who want to use family planning are not able to do so • decision-making control, and specific decision-making influencers in the household and community
Section 7a: Health Services: Antenatal Care	
7.1	How common is it for women in this community to go for clinical check-ups while pregnant? ***If not common**, listen/probe for:* • reasons why they do not go (e.g. specific factors that may prevent them from going) • any other types of providers they may visit (e.g., traditional) • what they may do as an alternative to ensure that their pregnancy and baby are healthy ***If common,** listen/probe for:* • where and/or by whom they receive the care • how far and by what means they travel to get there • who usually decides if they go (e.g. they decide alone, or someone influences or makes the decision for them) • whether they usually go alone, or together with their husband/partner/other • how early in the pregnancy they go for ANC • how many times during their pregnancy they go • the perceived importance of ANC

(Tool 3b-5 continued)

7.2	Use **beans** to have the participants show the percentage of women in the community that they think: • go for at least four ANC check-ups during pregnancy • are accompanied by their husband/partner for their ANC check-ups.
7.3	What are the types of services that pregnant women normally receive with ANC? *Listen/probe for:* • supplements/preventative, specifically: iron-folate tablets and Tetanus Toxoid injections • treatment, specifically: IPTp for malaria, de-worming tablets, PMTCT services • testing, specifically for: HIV, TB, Syphilis, and/or other common sexually-transmitted infections • comfort level with the care, specifically: the environment, service provider attitude and approach, service provider skill/experience
Section 7b: Health Services: HIV and TB	
7.4	How common is it for people (pregnant women especially) in this community to be offered routine testing for HIV during clinic visits? TB? *Listen/probe for:* • ideas/knowledge around why/why not testing usually happens • acceptance of the test (how common, and reasons why/why not women accept/do not accept) • decision-making around the testing (process, influences, etc.) • confidentiality of results
7.5	How do women in this community feel about testing for HIV and TB while they are pregnant? *Listen and probe for:* • beliefs about the need for and consequences of testing • stigma related to testing (emotional and/or psychological factors) • perceptions of husband/partner or other family members • issues about sharing one's status; if people do this or not • HIV and TB knowledge (effects for mother and baby) • potential barriers to testing
7.6	What are some of the ways that people prevent HIV infection in this community? *Listen and probe for:* • HIV knowledge/understanding and common sources of information • traditional beliefs/practices • gender dynamics • stigma, disclosure, support
Section 7c: Health Services: Skilled Birth Attendance	
7.7	Where do women in this community usually deliver their babies? *Listen and probe for:* • reasons why these places are chosen (key factors such as tradition, location, financial, etc.) • who influences and makes the decisions on where to deliver • how most women feel about this/these place(s) • differences in choice based on woman's health status and age at delivery, whether it's her first/second/third etc. delivery • if the way they are treated at the clinic makes a difference, and if people are treated differently based on their ethnicity, language, etc.
7.8	Please describe the person/type of health provider who normally delivers women's babies in this community. *Listen and probe for:* • qualifications (such as knowledge, training, practical experience, links to support, etc.) • reasons why this person is most appropriate or not appropriate • how most women feel about this person delivering their baby • how prepared is this person to respond to emergency situations • traditional beliefs and customs around labour and delivery

(Tool 3b-5 continued)

7.9	What advance preparations do you or other pregnant women and their families usually make in case there is an emergency or complication during the pregnancy or delivery? *Listen and probe for:* • common understanding of what an emergency situation is (e.g. danger signs – do they know them?) and the need for preparation • financial considerations • traditional beliefs • examples of success stories for having advance preparation
7.10	**Beans:** What percentage of women in this community do you think deliver at the health facility? *Listen and probe for:* • the reasons why/why not this number of women deliver at the facility • the value and importance of delivering at a facility • risks/challenges associated with delivery at a facility • barriers to having more facility births • personal feelings about delivering in a facility versus a traditional environment (comfort, respect, religious factors, etc.)
Section 7d: Health Services: Postpartum Care	
7.11	*(For facility births)* What type of care and check-ups do women receive after delivery, both on that day and in the days and weeks afterwards? *Listen and probe for:* • length of time women usually remain in the facility after birth, and whether or not the time is sufficient • factors that influence this (space, capacity, human resources, supplies, etc.) • differences in women's needs based on differences in pregnancies, types of deliveries, physical (or emotional) states, etc. • whether or not women feel this care is helpful and beneficial • cultural norms about returning to work or other responsibilities after delivery (considerations around time for rest and recovery, bonding with the baby, family adjustments, etc.) • receiving medications or vitamins, especially high dose vitamin A
7.12	(*For home births)* What type of care and check-ups do women who deliver at home receive after delivery, both on that day and the days and weeks afterwards? *Listen and probe for:* • descriptions around timing (cultural norms associated with sequestering mom/baby for a period, etc.) • influencing factors (family support, financial resources, traditional beliefs, etc.) • differences in women's needs based on differences in pregnancies, types of deliveries, physical/emotional states, etc. • whether or not women feel this care is helpful and beneficial • norms about returning to work/responsibilities after delivery (considerations around time for rest/recovery, bonding with baby, family adjustment, etc.) • receipt of medications or vitamins, especially high dose vitamin A
7.13	(*For all births)* What is the importance for both mother and baby to receive ongoing check-ups in the first few days and entire first month after the baby is born? *Listen and probe for:* • special health risks for babies in the neonatal period – infections, weight gain/loss, etc. • mothers' health in relation to healing body • mother's mental and emotional well-being • breastfeeding support as needed • recognition of danger signs, and support in referral/linkages
7.14	If the responses reveal little or no postpartum care, probe to understand the reasons.

Part Two – Children Under 2 (Tool 3b-5 continued)

No.	Questions
Section 1: Essential Newborn Care	
1.1	**Doll**: Use a doll to have the participants show what is usually done with the baby immediately after delivery. Discuss as a group. *Listen/probe for:* • cleaning airways, wiping, bathing, cord-cutting, cord and eye care, wrapping for warmth • skin-to-skin contact with mother • immediate breastfeeding • emotional responses – talking, singing, calming, making direct eye contact during breastfeeding, etc. • when these actions are performed • by whom these actions are performed and/or providing support to the mother to perform • role/involvement of the husband/partner during this time • factors that may prevent these actions from happening • agency the mother has to insist on these actions, if she wishes
Section 2: Appropriate Breastfeeding	
2.1	What are the normal breastfeeding practices and beliefs for newborn babies, in this community? *Listen/probe for:* • how soon after delivery babies begin breastfeeding • whether they are usually fed the colostrum – why or why not • anything else in addition to breast milk given during the first day or the first month • whether they are given water during these times (***Note:*** *repetitive of above question, but must be asked explicitly*) • whether they are given bottles with water or other liquid at any age • how often during the day and night mothers breastfeed during the first month • decision-making control over breastfeeding practices – how much the mother has, and who are the major influencers in the household and/or community
2.2	Beyond the newborn period (e.g., first month), what are the normal breastfeeding practices for a baby in the first six months of life? *Listen/probe for:* • exclusive breastfeeding – whether anything else in addition to breast milk is given during the first six months of life • whether babies are given water during this period (***Note:*** *repetitive of above question, but must be asked explicitly*) • how often during the day and night mothers breastfeed during this period • whether babies are breastfed 'on demand' (e.g., fed as often as they express hunger cues) • whether breastfeeding continues/increases/decreases during illness or diarrhoea – why or why not? • beliefs and reasons surrounding these practices • decision-making control over breastfeeding practices – how much the mother has, and who are the major influencers in the household and/or community
2.3	How does a lactating mother care for herself to ensure appropriate breastfeeding? *Listen/probe for:* • dietary changes – what are they, and why do they happen? • common challenges and/or problems with breastfeeding (e.g., sufficient milk production, infections, feasibility based on workload/time availability, etc.) – what do women do in response? • support lactating women receive to breastfeed appropriately – what types, and by whom? • in-depth understanding of influencers, both positive and negative • beliefs and reasons surrounding adequate maternal care during breastfeeding

(Tool 3b-5 continued)

2.4	How important is appropriate breastfeeding for the health, growth and well-being of the baby? *Listen/probe for:* • value from a nutrition perspective • value from an infection prevention perspective • value from an emotional well-being perspective (e.g., mother-baby bonding) • value from a life-long health perspective • beliefs and reasons surrounding all
Section 3: Hygiene and Handwashing	
3.1	Please describe the use of toilets and/or latrines in this community. *Listen/probe for:* • existence at the household level • practices around use • factors that facilitate and prevent use • common alternatives
3.2	Please describe the use of handwashing stations in this community. *Listen/probe for:* • existence at the household level • practices around use – How often? When? Always/usually/never with soap? • any soap alternatives (e.g., ash, salt, lime/lemon, etc.) • factors that facilitate and prevent use • common alternatives
3.3	Use **beans** to have the participants show the percentage of women in the community that they think wash their hands: • after using the latrine • before preparing food • before eating • before handling the baby • after disposing of faeces. *Listen and probe for:* • use of soap during these times • the reasons why/why not handwashing happens at these times • the value and importance of handwashing at these times • risks associated with not washing hands at these times • factors that may prevent women from handwashing at these times • perceptions around handwashing at these times • influential factors and/or people in the household and/or community
3.4	How do women/families conduct other types of daily washing? *Listen and probe for:* • washing of dishes • washing of clothing, sheets/blankets, etc. • bathing of children • use of soap for these types of washing • influential factors and/or people in the household and/or community around these washing practices

(Tool 3b-5 continued)

Section 4: Complementary Feeding and Growth Monitoring	
4.1	What are the normal complementary feeding practices and beliefs for babies and young children in this community? *Listen/probe for:* • age at which caregivers usually start feeding the baby other foods and liquids besides breast milk • what type of food is given in addition to, or instead of, breast milk • sources of animal protein, iron-rich foods, vitamin A-rich food • whether water is given to babies, and if/how it is sanitised/boiled first • whether iodised salt is included in baby's diet • if/how these practices change during illness or diarrhoea – why or why not? • beliefs and reasons surrounding these practices • decision-making control over complementary feeding practices – how much the mother has, and who are the major influencers in the household and/or community
4.2	Please describe the types of campaigns where growth monitoring is provided in the community. *Listen/probe for:* • where, and how often they take place • whether participants take their children to the campaigns for services – why or why not? • beliefs surrounding these campaigns- are they valuable? Why or why not? • alternatives to campaigns for child growth monitoring (e.g., clinic visits, etc.) • decision-making control over campaign or clinic attendance for growth monitoring – how much the mother has, and who are the major influencers in the household and/or community
4.3	Please describe the child growth monitoring cards that are used by families in this community. *Listen/probe for:* • how familiar participants are with the cards (e.g., their purpose, contents, etc.) • the importance/value that participants place on use of the cards • whether parents keep them up-to-date and stored in a safe, accessible location in their home
4.4	Use **beans** for participants to show the % of children in the community that they think have their growth monitored. *Listen and probe for:* • reasons that may facilitate or prevent parents from taking their children to growth monitoring • decision-making control over regular growth monitoring attendance – how much the mother has, and who are the major influencers in the household and/or community
Section 5: De-worming and Immunisations	
5.1	How commonly do parents and families take their babies and young children to the health clinic for regular de-worming and immunisation? *Listen and probe for:* • types of services normally available at the health clinic for de-worming and immunisations • other services available during de-worming or immunisation visits: vitamin A & iron supplements, growth monitoring • reasons that may facilitate or prevent parents from taking their children to the clinic • if multiple members of the family are treated for de-worming and/or immunised at the clinic simultaneously • decision-making control over clinic attendance – how much the mother has, and who are the major influencers in the household and/or community
5.2	Please describe the types of campaigns where immunisations are provided in the community. *Listen/probe for:* • where, and how often they take place • whether participants take their children to the campaigns for services – why or why not? • beliefs surrounding these campaigns- are they valuable? Why or why not? • decision-making control over campaign attendance – how much the mother has, and who are the major influencers in the household and/or community

(Tool 3b-5 continued)

5.3	How common is it for caregivers to make sure the child wears shoes at all times? *Listen/probe for:* • reasons why families may not ensure the child wears shoes • perceptions around why it is important to wear shoes – how does this contribute to better health, and what kinds of health problems are prevented by wearing shoes?
Section 6: Diarrhoea, Pneumonia (Acute Respiratory Infection) and Malaria	
6.1	Please describe the most common types of illness (sickness) that babies and young children suffer from in this community. *Listen/probe for:* • symptoms related to diarrhoea/pneumonia/malaria: loose/watery stools, coughing, difficult breathing, fever, etc • how parents and caregivers know that babies and children may be sick – what are the signs? • beliefs surrounding causes of these illnesses
6.2	What do mothers, parents, families and/or other caregivers normally do to care for a sick baby or young child? *Listen/probe for:* • ORT and/or zinc • increased breastfeeding and/or fluid intake • continued complementary feeding • any changes in sanitation or hygiene • treatment and/or care-seeking outside of the home • perceptions and beliefs around diagnostic tools (e.g., microscopy or RDT) or antibiotic treatment regimes
6.3	What signs of sickness are serious enough for families to seek out treatment for the child? *Listen/probe for:* • high or prolonged fever • fast or difficult breathing • indrawn ribs or nasal flare • persistent vomiting • change in consciousness, seizures or unresponsiveness • inability to breastfeed or drink • chills or joint pain • sunken eyes, dry lips or loose skin • frequent (more than 3x per day) watery stools or stools with blood
6.4	Where do parents and caregivers usually take a sick baby or child for treatment? *Listen/probe for:* • clinic/facility • traditional health practitioner • decision-making control over seeking care for treatment – how much the mother has, and who are the major influencers in the household and/or community
6.5	Use **beans** to have the participants show the percentage of families in the community that they think: • have bed nets in their homes • regularly use their bed nets for babies and children • use stoves or open cooking fires inside the home • have access to safe water sources and/or disinfect water/fluids given to babies/young children.
Section 7: Birth Registration	
7.1	Please describe practice of birth registration for babies born into this community. *Listen/probe for:* • perceptions around benefits/value for child and family • when families normally register the birth of their child • where families normally register the birth of their child • what factors might prevent families from registering their child's birth

TOOL 3B-6. 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.
   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.
- 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 and then go on to 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?

Roles

Daughter of a banker, attending a private school. You sponsor a child and writes 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 3B-7. 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 or 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 family ill member
- in a child-headed household
- children married at a young age
- immigrants or refugees
- in a family with women who sell sex
- households that have taken in orphans
- households where 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 3B-8. 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 reflect 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 3B-9. COMM ACTION PLANNING AND MONITORING TOOL: ROOT-CAUSE ANALYSIS

ROOT-CAUSE ANALYSIS

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 goals of completing a root-cause analysis of health issues in the community. Tick the box under 'Goal' only when the activities are complete and the goal has been achieved.

Goal

☐ The full root-cause analysis is complete (includes all interview and FGDs, as well as analysis of the information).

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

(Tool 3b-9 continued)

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

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