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TRIP REPORT
VISIT FOR REVIEW OF ASSESSMENT CRITERIA
RWANDA

June 14 - 25, 1993

by
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Wellstart International's Expanded Promotion of Breastfeeding (EPB) Program

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ABBREVIATIONS

BFHI	Baby Friendly Hospital Initiative
DHS	Demographic and Health Surveys
EPB	Expanded Promotion of Breastfeeding Program
IEC	Information, Education, Communication
KAP	Knowledge, Attitudes, Practices
LME	Lactation Management Education
MCH/FP	Maternal and Child Health/Family Planning
MEDIRESA	Regional Medical Officer
MINISANTE	Ministry of Health
MORE	Maximizing Operations Research Results Project
OR	Operations Research
PHC	Primary Health Care
PRICOR	Primary Health Care Operations Research Project
RIM	Rwandan Integrated Maternal Child Health/Family Planning Project
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID/Kigali	U. S. Agency for International Development in Rwanda
USAID/W	U.S. Agency for International Development in Washington, DC
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

Dr. Ann Brownlee, Wellstart International's Technical Advisor for Program Development and Evaluation, worked in Rwanda from June 14-26, 1993.

The purpose of the visit was:

- To work with the Rwandan Integrated Maternal Child Health/Family Planning (RIM) Project teams on the development of the RIM assessment instruments, particularly as they are related to breastfeeding and weaning foods.

In addition, it was planned that discussions initiated by Ms. Anna Martin, Wellstart EPB Program Associate, concerning selection of a Rwandan team for Wellstart's francophone Lactation Management Education (LME) course would continue during the visit.

Activities and Assessment Tools Developed

- Participation in regional review meetings on delivery and post natal care
- Discussions concerning assessment strategies
- Technical work on development of breastfeeding/weaning/maternal nutrition components of the RIM Project assessment instruments
- Discussions concerning strategies for selection of appropriate teams for the Wellstart LME course and program.

The core of the assignment focused on critique, revision, and (in some cases) initial development of the breastfeeding, weaning and maternal nutrition components of several assessment tools that would be field tested and utilized by the Project. Products developed included:

1. Critique and proposed changes in the breastfeeding-related sections of the RIM Project population-based survey instrument.
2. Development of breastfeeding components for facility-based service quality checklists for antenatal care, delivery and immediate postpartum, postnatal care, and family planning services.
3. Development and/or presentation of several additional tools for assessment of the breastfeeding and weaning content of the Project. These included:
    - Questions for an "exit survey" of mothers after delivery that can be used to gather data for key breastfeeding indicators in maternity facilities.
    - Questions for breastfeeding focus group discussions that can provide additional "in depth" insights into breastfeeding and weaning knowledge, attitudes and practices.

Conclusions and Recommendations

- **Development of indicators and collection of data both for program design and for measuring program achievements.** The RIM Project faces a challenge in attempting to collect information that will provide useful baseline data on important indicators and, at the same time, be helpful for program planning and design. It is recommended that the Project focus, for baseline purposes, on gathering information on key intermediate variables, which have been shown by prior studies to result in long term impacts on maternal and child health, as well as population growth. The population-based instrument was revised, to focus more clearly on these variables.

  The population-based instrument and tools for health facility assessment have also been designed to provide some useful information for program design. It is recommended that use of focus groups be considered, as well, as they can provide much of the additional in-depth information needed for program design and selection of information, education and communication (IEC) strategies and methods. Guidelines for focus group selection and sample questions have been included in the report.

- **Involvement of Ministry of Health (MINISANTE), regional and health center staff in a participatory, problem-solving approach.** A final objective of the assessment process is integral involvement of the MINISANTE, regional, and health center staff, as this is key to the participatory problem-solving approach the Project wishes to foster. The approach used in the Burkina Faso "Operations Research (OR) Project" is a useful model to consider.

- **Participation in the "Baby Friendly Hospital Initiative" (BFHI).** It is fortuitous that both the BFHI and RIM Project are getting started at nearly the same time in Rwanda and that there are plans for collaboration. The Project, MINISANTE, the regional teams, and UNICEF are exploring how the staff in the two regions might best participate in BFHI. Apparently, one approach UNICEF and the Project have already decided to emphasize, is fostering "Baby Friendly Health Centers". One step in the process could be to revise the "10 steps" so they are appropriate for the Health Centers. Part of the training and IEC activities planned could focus on raising the awareness of family members and Traditional Birth Attendants (TBAs) on how they can best support breastfeeding and perform "baby friendly" home deliveries.

- **Selection of teams for Wellstart training.** Wellstart Program participation can play a critical part in strengthening the knowledge and skills needed by the health professionals at central and regional levels who will play key roles in both management and training within the breastfeeding component of the RIM Project. The addition of two key professionals at the two Baby Friendly hospitals (in Kigali and Butare) will add depth to the Baby Friendly Initiative and they can be drawn upon in RIM Project activities as well. The Project, MINISANTE, the Regional Medical Officers (MEDIRESAs) and the United Nations Children's Fund (UNICEF) should further discuss the best composition of the team to be sent to San Diego. Care should be taken to select strong multidisciplinary teams of health professionals (pediatricians, obstetricians, nurses, nutritionists) who will play a key role in breastfeeding education and training, both at central and regional levels.

I. BACKGROUND

An assessment of breastfeeding activities in Rwanda was conducted by Wellstart International's EPB Program, in April-May 1992, in collaboration with the U.S. Agency for International in Rwanda (USAID/Kigali) and the Division of Maternal Child Health/Family Planning (MCH/FP) at MINISANTE. Based on the findings of the report, a proposal was developed for an add-on from USAID/Kigali, which was designed to assist with the integration of breastfeeding into a new USAID/MINISANTE effort, the RIM Project, and to work with MINISANTE and UNICEF as the BFHI began in Rwanda.

The proposal was written in late 1992. Initial technical visits were scheduled to take place in March 1992 but, due to civil unrest, the activities were postponed. The add-on was finally received in May 1993, and Ms. Anna Martin of EPB traveled to Kigali in early June 1993 to determine a new timeline for Wellstart assistance, as well as to plan for a national conference to be held in conjunction with BFHI activities and to begin work with the RIM project team on its process for assessing rural health centers in the regions of Kibungo and Gitarama. This visit is part of the scheduled collaboration between Wellstart, MINISANTE and USAID/Kigali on the RIM Project assessment process.

II. PURPOSE OF TRIP

This trip was undertaken by Wellstart International's Technical Advisor for Program Development and Evaluation, Dr. Ann Brownlee, from June 14-26, 1993, as one of Wellstart EPB's activities to support the breastfeeding, maternal-infant nutrition components of the RIM Project.

The purpose of the visit was:

- To work with the RIM Project teams on the development of the RIM assessment instruments, particularly as they are related to breastfeeding and weaning foods.

In addition, it was planned that discussions initiated by Ms. Martin concerning selection of a Rwandan team for Wellstart's francophone LME course would continue during the visit.

III. ACTIVITIES AND FINDINGS

Several key activities were undertaken as part of the assignment:

- Participation in regional review meetings on delivery and post natal care
- Discussions concerning assessment strategies
- Technical work on development of breastfeeding/weaning/maternal nutrition components of the RIM Project assessment instruments
- Discussions concerning strategies for selection of appropriate teams for the Wellstart LME course and program.

Each of these activities and the findings resulting from them will be discussed in turn.

A. Participation in Regional Review Meeting on Delivery and Post Natal Care

Dr. Brownlee participated with RIM Project and MINISANTE staff in a series of regional review meetings scheduled in the Gitarama and Kibungo Prefectures, to review current practices, constraints, and recommendations for improvement in the key MCH/family planning areas of antenatal care, delivery, and post natal care. The meetings brought together representatives from the service delivery sites in each of the regions to review the key issues related to each of these components of perinatal care. The antenatal care sessions took place the week prior to Dr. Brownlee's arrival and were attended by Ms. Martin. Dr. Brownlee attended the sessions in each of the regions on both delivery and postnatal care. The meetings and discussions with the staff involved in them helped to give an idea of the range of activities that staff believe should be part of each of these service components and the constraints they face in actual execution. The meetings, coupled with visits to several of the Health Centers while in the field, provided greater perspective on the realities of local care, delivery and how breastfeeding, weaning and maternal nutrition components might be enhanced, as part of a strengthened integrated service approach.

During the discussions on postnatal care, the meeting participants in each region were asked to address breastfeeding practices and the role of health providers. The discussions provided quite useful information on local practices, which tended to confirm many of the results of the earlier Wellstart Breastfeeding Assessment. Briefly, the groups reported that:

- Babies are often put to the breast "immediately" after delivery but, in some cases, mothers wait up to 24 hours "for the milk to come in", with sugar water given in the meantime. While most discussants didn't know where the "24 hour" provision came from, one experienced nurse remembered that years ago, health workers themselves had started giving the advice to wait. There is still a tendency to believe that sugar water is an appropriate solution until the milk comes in.

- There appears to be little understanding of the effects of demand upon supply.

- A number of people mentioned that insufficient milk is very common, especially among malnourished women.

- Understanding of the importance of exclusivity, for its contraceptive effects, is just starting to take hold in some health centers.

- Rooming-in is universal. There is no formula distribution in maternities or hospitals. (One health worker suggested that maybe the RIM Project could provide some formula (!), which illustrates the need to raise consciousness on this issue and practice some "preventive protection".)

- Rwandan women feel free to breastfeed in public, although some suggested that the place chosen for nursing should be calm and quiet, for the baby's sake.

- Expression of milk, for any reason, is not common, and seems to be considered somewhat strange by many people. Most felt that it would be impractical for working women to store expressed milk, since most homes lack refrigeration. It is common to give the baby a sorghum porridge while the mother is gone.

- The idea of "milk banking" was discussed. There was concern that some mother's milk may be contaminated. The possibility of AIDS being transferred through breastmilk was discussed. There did not appear to be widespread panic concerning this risk and the idea, explained by RIM staff, that the risk from lack of breastfeeding was much greater, seemed to be accepted by all.

- Kangaroo care was discussed. It was something of real interest to the health workers present, but none had tried it. One technique mentioned for keeping a premature baby warm was to dig a hole next to the fire and put the baby in it, with some extra coals scattered around.

- It was mentioned that, traditionally, many women believe that if they stop breastfeeding for more than three days they should not start again, as the breastmilk will be spoiled.

There generally appeared to be great interest in the subject of "mothers milk", the physiological aspects of breastfeeding, and new techniques for solving feeding problems. It was agreed that additional training in this area would be quite useful.

B. Discussion Concerning Assessment Strategies

Discussions were held with the RIM Project Manager, Chris Grundmann, and other members of the RIM staff concerning the general approach to be taken to assessment and its role in providing both a baseline and essential information for project development.

We discussed the participatory approach used by the Burkina Faso OR Project[1] involving center supervisors and staff in an integral way in problem identification, objective setting and monitoring the their own progress, a strategy that greatly increased staff commitment to positive change. The Project had been successful in developing an integrated approach to MCH/family planning, beginning in the health centers of Ouagadougou. We found we had a "shared vision" concerning the importance of this dynamic. The Project is even planning a "study tour" for key MINISANTE and regional staff to see the Burkina program in action.

C. Technical Work on Development of Breastfeeding, Weaning and Maternal Nutrition Components of the RIM Project Assessment Instruments

The core of the assignment during the two weeks focused on critique, revision, and (in some cases) initial development of the breastfeeding, weaning and maternal nutrition components of several assessment tools due to be field tested and utilized by the Project in the next few weeks. Products developed included:

1. **Critique and proposed changes in the breastfeeding-related sections of the RIM Project population-based survey instrument.** A first draft of the instrument had already been developed by Sosthene Bucyana. Chris Grundmann, Anna Martin and others at Wellstart had provided initial feedback, focusing on the infant feeding and nutrition sections. Taking those comments and Dr. Brownlee's observations into account, the various breastfeeding and weaning sections of the instrument were redrafted and a critique and some suggested rewording of other questions were provided. This feedback, provided to the Mission in French, is found in Annex B. It will be used as "raw data" as the second draft of the instrument is prepared.

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[1] Prior to working full-time for Wellstart, Dr. Brownlee consulted for the MORE Project, making a "revisit" to provide an overview and critique of the assessment and program development process used in the Burkina Faso OR Project.

Dr. Brownlee suggested the addition of a new section on the feeding practices of children under 24 months of age. These new questions, adapted from the sample set developed by the WHO Working Group for use at the household level (WHO 1991), can provide data for standard international breastfeeding indicators. The approach is based on "24 hour recall" and thus may provide more accurate data than questions relying on recall over a much longer period.

As revisions were made to the breastfeeding-related sections of the components of the instrument already developed, wording of questions was adjusted whenever possible, so data gathered could be used to calculate the rates suggested by the recent WHO Working Group for development of breastfeeding indicators for health facilities (WHO 1993).

2. **Development of breastfeeding content for facility-based service quality checklists.** This task proved more of a challenge, since these instruments had not yet been developed. Chris Grundmann and Dr. Brownlee discussed various types of instruments that had been used by contractors, projects and Ministries in the past to assess quality of care of various components of MCH/reproductive health and their assets and drawbacks, from their experience.

Both had worked closely with the Primary Health Care Operations Research Project (PRICOR) in various capacities in the past and had experience in using its "PHC Thesaurus" or various offshoots of this document, such as the PHC rapid quality assessment and service quality checklists produced for the Aga Khan Foundation (DiPrete 1991 and Reynolds 1991). We agreed that rapid assessment tools somewhat similar in format to those developed by PRICOR, but adapted to the realities of Rwanda, with several changes in format,[2] would be useful. Dr. Brownlee therefore used the "rapid" service quality checklist format as an initial tool for assessing the breastfeeding and weaning content of services provided during:

- Antenatal Care
- Delivery and Immediate Postpartum Care
- Postnatal Care, and
- Family Planning Services.

The technical and clinical content proposed for breastfeeding and weaning for each of these components of perinatal care and family planning are in the process of being reviewed by the Wellstart LME medical and nursing faculty and are presented in draft form in Annex C. Although this may not be the final form the facility-based instruments may take, it served as a systematic way to present the breastfeeding and weaning content that should be integrated into whatever tools are finally devised.

[2] The format of the tools was revised somewhat from that used by PRICOR, based on initial discussions of certain drawbacks in the PRICOR tools. The scoring systems, for example, were expanded from "yes"/"no" to "not done", "done partially or incorrectly", "done correctly" and "don't know". "Key points" to look for were added for certain tasks whose quality would be difficult for observers to judge, without some additional information. Two alternative formats, with the scoring at right and left, are presented for comparison.

3. **Development and/or presentation of several additional tools for assessment of the breastfeeding and weaning content of the Project.** These include:

- **Questions for an "exit survey" of mothers after delivery that can be used to gather data for key breastfeeding indicators in maternity facilities.** These indicators and sample questionnaires were recently developed by WHO and UNICEF, with the participation of various organizations concerned with breastfeeding, including Wellstart. A translation of the questions proposed by the WHO Working Group (WHO 1993) is presented in Annex D.

  Since the number of deliveries per month is very few in most health centers within the Project area, only a very small number of mother interviews (if any) could be completed in the two-day assessment visits to each Center planned during the assessment phase of the Project. The questionnaire, however, is quite simple and the indicators easy to calculate. The data could be gathered by the Center staff itself, as part of an on-going internal monitoring and evaluation system.

- **Questions for breastfeeding focus group discussions that could provide additional "in depth" insights into breastfeeding and weaning knowledge, attitudes and practices.** The information gathered would be particularly helpful as health education/IEC components of the Project are developed. Annex E includes both these sample questions and a short and useful article on the organization of conduct of focus group discussions, reproduced from the French version of "Rapid Assessment Procedures for Nutrition and Primary Care" (Kidima, Scrimshaw and Hurtado, 1990).

- **The Baby Friendly Hospital Initiative (BFHI) Self Appraisal Tool (in French).** This could be used by hospital, maternity and health center staff, as part of a "self assessment" of how closely their services follow the internationally agreed upon "10 steps for successful breastfeeding" that are featured in the BFHI. Wellstart collaborated closely with UNICEF to develop this tool and certain other aspects of the BFHI assessment process. The BFHI Self Appraisal Tool is not presented in the report, as it is easily available from the local UNICEF Office.

  Self appraisal, of course, may produce results biased in the institution's favor, but can be part of an important first step in sensitizing administration and staff to change in policies and procedures that foster successful breastfeeding.

D. Discussions Concerning Strategies for Selection of Appropriate Teams for the Wellstart LME Course and Program

Finally, discussions were held with Mission, RIM Project, and UNICEF staff concerning the best use of the positions for Rwanda in the francophone LME course. The importance of sending multidisciplinary teams (including physicians, nurses, and, if possible, nutritionists) and other criteria for selection were discussed with the RIM Project Manager, the Regional Medical Officers (MEDIRESAs) for Gitarama and Kibungo, and the UNICEF Nutrition Officer.

All concerned felt strongly that the teams to send to the Wellstart Program should include teams of two people from each of the two regions where the RIM Project would be operating and two key individuals from the two Baby Friendly Hospitals (in Kigali and Butare). The possibility of locating a team that was both based in a regional hospital and teaching on the regional training team was explored with both MEDIRESAs during visits to the two regions. They both felt this was not likely to be possible. They emphasized that the staff of the regional hospitals were usually quite different than the members of the regional training teams, and that, as most births were at home, with prenatal visits to the Health Centers, the hospitals had little influence. Thus, they felt key members of the regional training teams would be most appropriate.

Another alternative was suggested, to send a larger team from one region and the central level, with the final team from the other region coming to the next francophone course. The importance of a "critical mass" for effecting change in each setting was discussed. The RIM Project Manager felt it was very important that teams from both regions come at once, even though this meant they would each be smaller.

The criteria for selection were again summarized during a meeting of Project staff and the two MEDIRESAs in Kigali just before departure. It was agreed that further information would be sent from the Wellstart LME Program and appropriate team members be proposed as the time for the course got closer.

IV. CONCLUSIONS AND RECOMMENDATIONS

A. Assessment Objectives and Strategies

The assessment being planned during the initial or "bridge" phase of the RIM Project could be designed to serve one or more of the following purposes:

- To provide baseline data against which progress can be measured as project activities get underway
- To provide information that will be of use in the more detailed design of program strategies and activities
- To involve MINISANTE, regional, and health center staff in a participatory problem solving approach, providing them with assessment tools which they can use to identify areas needing improvement and to monitor progress made.

Hopefully, the assessment being designed can serve all three purposes, as the RIM Project paper seems to indicate it should.

1. **Provision of baseline data for measuring program achievements.** Design of the assessment so it will provide useful baseline data on important indicators involves a challenge, in that the data will also be used for formative or planning purposes. Since all aspects of project design are not yet finalized, it is difficult to be sure that the indicators selected will measure all important aspects of project change. (Some additional work will thus need to be done later this year to finalize the evaluation plan.)

   A useful complementary strategy is to focus, for baseline purposes, on gathering information on key <u>intermediate variables</u>, which have been shown by prior studies to

result in long term impacts on maternal and child health, as well as population growth. A useful article by Van Norren et al. (1989), "Simplifying the Evaluation of Primary Health Care Programmes", promotes the measurement of intermediate variables, as a cost effective and feasible approach to program evaluation. Two diagrams presented in the article (and reproduced on the following page) indicate the role of intermediate variables in affecting child health and survival and identify some of the most important variables to consider. The diagram, if expanded slightly, could just as easily apply to maternal health and survival as well.

As can be seen in the second diagram, "breastfeeding", "mode of feeding", "weaning" and "nutritional behaviors" are important intermediate variables, as are a number of the other behaviors and practices targeted by the RIM Project (i.e., reproductive pattern (e.g. spacing), immunization in pregnancy, perinatal care, etc.).

In her work on the breastfeeding-related sections of the population-based instrument, Dr. Brownlee focused on redrafting a number of the questions so they accurately measure several key breastfeeding behaviors, using the international indicators for both the household and facility levels, recently reviewed in two WHO Meetings (WHO, 1991 and 1993). If necessary, the data gathering can concentrate on a somewhat more limited set of breastfeeding indicators, and the set of questions trimmed accordingly.

Recommendation: As other components of the assessment are finalized, careful thought should be given to what the key indicators in other program areas should be.

2. **Provision of information for program design.** As mentioned earlier, an important purpose of the assessment, at the same time, is to provide useful information of help in more detailed program design. Both the population-based instrument and strategies to be used in the two-day assessment visit to each of the Centres in the Project areas should be finalized, keeping this purpose well in mind.

As the breastfeeding portions of the survey instrument were reviewed, questions were eliminated that neither served this purpose nor provided additional information for calculating key indicators. There is much additional information that cannot be easily captured by a survey instrument of the type proposed. Focus groups, as mentioned earlier, can provide much of the additional in-depth information needed for program design and selection of IEC strategies and methods.

Some of the information needed is already available from past breastfeeding assessments, KAP studies and focus group discussions.[3]

Recommendation: The final instruments should be reviewed, before field testing, to determine to what extent they focus on gathering information of real practical use for program design, and should be adjusted, as necessary. A series of focus group discussions on key areas where further in-depth understanding is needed for program

[3] See, for example, the list of studies in the "references" section of the Wellstart "Breastfeeding Assessment for Rwanda", recent studies UNICEF and by Bona Hategekimana and colleagues at MINISANTE.

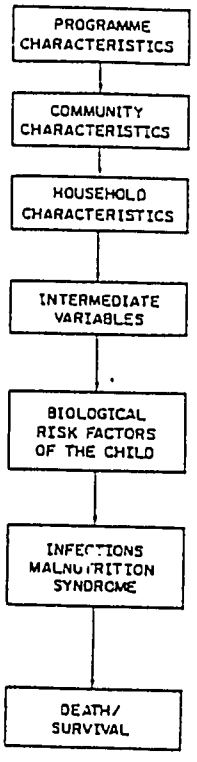

Fig. 1. Processes through which PHC programmes affect child health.

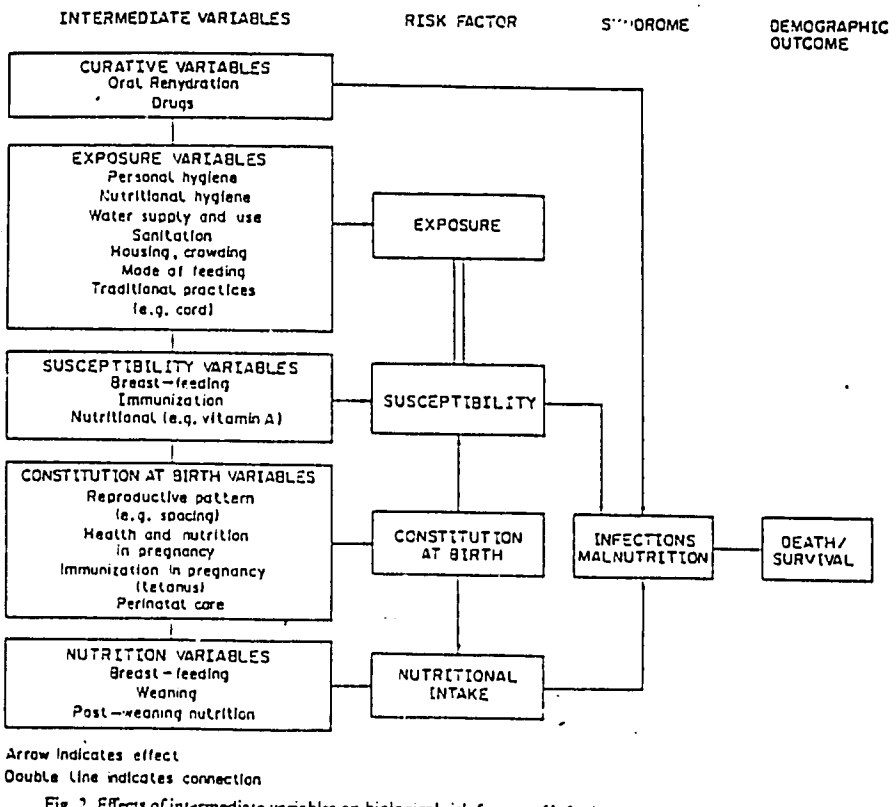

Fig. 2. Effects of intermediate variables on biological risk factors of infections–malnutrition syndrome and child survival.

From Van Norren B et al. Simplifying the evaluation of primary health care programmes, *Soc. Sci. Med.* 28(10):1092-3.

design and IEC strategy development should be held. Group discussions could be held with various homogeneous groups such as mothers of child-bearing age, older women, men, health workers, and TBAs. The design and conduct of some or all of the focus groups could wait, if necessary, until the staff of the contracting organization arrives.

3. **Involvement of MINISANTE, regional and health center staff in a participatory, problem-solving approach.** This last potential objective of the assessment is key to the ultimate success of the RIM Project. MINISANTE, regional, and health center staff's involvement throughout the assessment process, (in addition to its design) should be the first step in the participatory problem-solving approach the Project wishes to foster.

The Burkina Faso "OR Project" which focused on development of an integrated approach to MCH/family planning, is a useful model to consider, as Project staff is well aware. The participatory process used in Burkina involved several steps, including:

- Training of Ministry and Health Center staff in both technical aspects of family planning/MCH and the problem-solving approach to program improvement.

- Organization of an "equipe de suivi" (Ministry supervision team) which works with each of the health centers involved to help them to:

  - assess the current status of their service delivery programs
  - identify problem
  - develop a small number of measurable and achievable objectives and a work plan to achieve them
  - gather data to measure progress.

  Simple program assessment and data collection tools were devised which each center group could use, as desired, to assess their own situations and measure progress.

The quality of service checklists, as well as simple questionnaires for interviews with service users and even guidelines for simple focus groups on key topics, are all tools that could be used by regional and health center staff themselves to assess community KAP and needs, the current status of their centers, and problem-areas to be addressed, as well as to measure progress made. The checklists and other protocols which either already exist or will be developed within the Project, can be used for training and supervision purposes as well.

Recommendation: In the next month or so, when the assessment tools are being finalized, it would be helpful to keep in mind their potential use as part of the participatory, problem-solving approach the Project hopes to encourage.

B. Emphasis on Community Members and/or Traditional Birth Attendants (TBAs) in Project Assessment and Outreach Activities

A continuing theme that emerged during the discussions in Gitarama and Kibungo was the fact that 80% of the births take place at home, and thus the role of family members and TBAs in perinatal care is a substantial and important one. Training and IEC activities that reach these women were suggested as an important component to consider, as RIM Project strategies are finalized.

Recommendation: In view of the importance of family members and/or TBAs in perinatal care, it would be important to focus part of the assessment on gaining a greater understanding of their roles, current practices, and needs for further training. Wellstart, if desired, could contribute ideas concerning important issues to explore related to the KAP and potential role of TBAs in breastfeeding and weaning.

C. Participation in the "Baby Friendly Hospital Initiative (BFHI)"

It is fortuitous that both the BFHI and RIM Project are getting started at much the same time in Rwanda and that there are plans for collaboration. In several countries the scope of BFHI has been expanded in one or more ways. In Mexico, for example, the Initiative was broadened to stress "Mother Friendliness" and other key child survival areas as well. In Myanmar (formerly Burma), the great majority of women deliver at home, much as here in Rwanda, and UNICEF and the Government of Myanmar are working to devise a "Baby Friendly Community" approach.

Recommendation: The Project, MINISANTE, the regional teams, and UNICEF should continue to explore how the staff in the two regions might best participate in BFHI. Apparently one approach UNICEF and the Project have already decided to emphasize is fostering "Baby Friendly Health Centers". One step in the process could be to revise the "10 steps" so they are appropriate for the Health Centers. Part of the training and IEC activities planned could focus on raising the awareness of family members and TBAs on how they can best support breastfeeding and perform "baby friendly" home deliveries.

D. Selection of Teams for Wellstart Training

Wellstart Program participation can play a critical part in strengthening the knowledge and skills needed by the health professionals at central and regional level who will play key roles in both management and training within the breastfeeding component of the RIM Project. The addition of two key professionals at the two "Baby Friendly" hospitals (in Kigali and Butare) will add depth to the BFHI. These individuals can be drawn upon in RIM Project activities as well.

Recommendation: The Project, MINISANTE, the MEDIRESAs and UNICEF should further discuss the best composition of the teams to be sent to Wellstart's LME course in the near future. Care should be taken to select strong multidisciplinary teams of health professionals (pediatricians, obstetricians, nurses, nutritionists) who will play key roles in breastfeeding education and training, both at central and regional levels. The possibility might still be considered of sending a three-person central team (one person from MINISANTE, two people from the Baby Friendly Hospitals) and a three-person team from one of the regions (with the second regional team coming later), rather than three teams of two persons each.

E. RIM Project/Wellstart Collaboration to Develop a Replicable Approach to Delivery of Integrated Services

It appears that it will be quite mutually beneficial for Wellstart to collaborate with the RIM Project, MINISANTE and the staff in the two pilot regions to strengthen MCH/family planning service delivery, with breastfeeding, weaning and nutrition integrated whenever appropriate.

Recommendation: As the assessment, training and supervision strategies are developed that will strengthen integrated MCH/family planning service delivery, it will be important to develop assessment tools, training curricula, and supervision protocols that can be easily and successfully used again, as the approach expands to additional regions. Wellstart should contribute to the development of the

breastfeeding, weaning, and nutrition aspects of these tools, curricula and protocols. The materials produced can hopefully serve as models for use in other countries.

V. FOLLOW-UP ACTIONS

Next Steps for the Wellstart EPB Program:

1. Review trip report and proposed instruments, offering suggestions for revisions for the final draft.

2. Provide further feedback as requested, as the RIM Project continues the process of assessment tool development and finalization in the next few weeks.

Next Steps for the Wellstart LME Program:

1. Assist with technical and clinical review of the breastfeeding and weaning components of the quality of service checklists.

2. Continue to coordinate with Wellstart EPB and RIM Project/MINISANTE and UNICEF staff on identification of appropriate candidates for LME training and scheduling their participation in the francophone course.

Next Steps for RIM Project/Mission Staff:

1. Review the trip report and proposed instruments, requesting any revisions desired for the final draft.

2. Request Wellstart input, as desired, as assessment instruments are further developed and finalized.

3. Work with the MINISANTE, regional staff, and UNICEF to make final determination concerning participants for the Wellstart francophone LME course.

ANNEX A

LIST OF CONTACTS

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ANNEX B

POPULATION-BASED SURVEY INSTRUMENT – PROPOSED CHANGES IN THE BREASTFEEDING-RELATED SECTIONS AND ADDITIONAL SUGGESTIONS

MEMORANDUM

TO: Chris Grundmann, Sosthene Bucyana, Project RIM
FROM: Ann Brownlee
DATE: June 19, 1993
SUBJECT: "Project RIM Population-Based Survey Instrument" -- Proposed changes in the breastfeeding-related sections and additional suggestions for revision

Attached are my suggestions concerning the first draft of the "Population-Based Survey Instrument" for the RIM Project. As requested, I have concentrated on the breastfeeding-related sections of the proposal. The proposed revisions are presented in table form similar to that in the initial instrument. Additional suggestions concerning other sections of the instrument appear in between. All comments are referenced to the initial question numbers, for hopefully easy referral. As you'll see, I've suggested an additional section on "Care during the Postnatal Period", and included a first draft, with emphasis on the breastfeeding components. A section related to "Family Planning Services" should be added, as well, as these services are provided separately in some facilities that will participate in the Project.

As you will see, I've suggested some substantial revisions in the breastfeeding-related sections. In many cases, I've adapted the instrument so it gathers information that can be used to calculate WHO Breastfeeding Indicators that have been recently developed, with Wellstart's participation, for both the household and facility levels. In addition, I've suggested eliminating some breastfeeding-related questions, when I couldn't determine how the information gathered could be used.

These suggestions must be considered, of course, in light of all the aspects of MCH/family planning that the RIM Project must cover. When a full second draft is made, it is likely that the number of indicators related to breastfeeding for which information is gathered will need to be reduced.

If choices have to be made, I would suggest that the breastfeeding-related section based on "24-hour recall" (i.e., the new section entitled "Alimentation des Enfants de Moins de 24 Ans") be retained, since 24 hour recall has been shown to provide much more accurate data than questions asking mothers to report for a much longer period. The information in the current version of the questionnaire related to the breastfeeding-related activities during prenatal care, delivery, and the postnatal period could, alternatively, be gathered by observations at the facilities themselves by "exit interviews" with mothers after their prenatal and postnatal visits, and just before discharge after delivery.

Focus group discussions should also be considered, as a good method to gather more "in-depth" information on knowledge, beliefs and practices in the population and possibly providers, as well, that can be used in the design of IE&C activities. (See Annex E for a list of potential breastfeeding-related questions that could be explored through focus groups.)

PROJET RIM POPULATION-BASED SURVEY INSTRUMENT

PROPOSED CHANGES AND ADDITIONS IN THE BREASTFEEDING SECTIONS

VISITES DE L'ENQUETRICE

INFORMATION DE BASE

(à compléter)

ALIMENTATION DES ENFANTS DE MOINS DE 24 MOIS

110	Combien d'enfants avez-vous qui ont moins de 24 mois?	. . . . . 1 . . . . . 2 . . . . . 3 4
111	Quels sont leur prénoms, en commençant avec le moins âgé?	. . . .

Pour chaque enfant de moins de 24 mois, demandez les questions suivantes:

112	Quel âge a (NOM) aujourd'hui? (dans la mesure du possible, donnez sa date de naissance).	. . . . .
113 OMS HH ind.	Depuis hier à la même heure, a-t-il été allaité au sein?	Oui . . . . . 1 Non 0
114 OMS HH ind.	Si oui, est-ce que le lait maternel a été sa source principale d'alimentation?	Oui . . . . . 1 Non 0
115 OMS HH ind.	Depuis hier à la même heure, (NOM) a-t-il reçu? (Lire la liste:)	Des vitamines, suppléments minéraux, médicaments? 1 De l'eau? . . . . . 2 De l'eau sucrée ou aromatisée? . . . . . 3 Des jus de fruits? . . . . . 4 Du thé ou des tisanes? . . . . . 5 Une préparation pour nourrissons? . . . . . 6 Du lait en conserve, en boîte, ou frais? . . . . . 7 Des aliments solides ou semi-solides? . . . . . 8 Une solution de sels de réhydratation orale (SRO)? 9 Bouille de sorgho? . . . . . 10 Autres (précisez): . . . . .
116 OMS HH ind.	Depuis hier à la même heure, l'avez vous nourri á l'aide d'un biberon?	Oui . . . . . 1 Non 0

16

117 *(Continuez ici pour les autres enfants de moins de 24 mois: laissez suffisamment de place pour 3 autres enfants de moins de 24 mois).*

UTILISATION DES SOINS PRENATALS POUR LA DERNIERE NAISSANCE

201: Avez...prénatals pour la dernière naissance?

202-208: Révisez pour reflèter les phrases exactes au cours de l'enquête.

208: Voir # 310 pour révision

Questions sur l'allaitement maternel:

(METTRE APRES QUESTION #208):

209 rev	Avez-vous reçu des informations ou conseils pendant le(s) visites prénatales?	Oui . . . . . 1 Non 0
210 rev	Avez-vous reçu des informations sur:	L'alimentation? . . . . . 1 Le gain pondéral? . . . . . 2 Les symptômes de risque? . . . . . 3 La date prévue d'accouchement? . . . . . 4 L'anémie/goitre? 5
neuf	Au cours de votre (vos) visite(s) prénatales, vous a-t-on parlé de la facon de nourrir votre bébé?	Oui . . . . . 1 Non 0
neuf	(Si oui), avez-vous reçu des informations sur:	Comment préparer un biberon? . . . . . 1 Les avantages de l'allaitement maternel? . . . . . 2 L'importance d'allaiter immédiatement après la naissance? . . . . . 3 L'importance du colostrum? . . . . . 4 L'importance de l'allaitement maternel, exclusif jusqu'á 4 ou 6 mois? . . . . . 5 Autres (précisez): . . . . .
neuf	Au cours de votre (vos) visite(s) prénatales, vous a-t-on parlé de la planification familiale?	Oui . . . . . 1 Non 0
neuf	Si oui, avez-vous reçu des informations sur: (Preparer liste des points cle pour la PF) . . .	. . . . . 1, Etc.

CONTINUER AVEC QUESTIONS #211

212-215

216: VAT = vacciné anti-tétanus (?)

217-220

ACCOUCHEMENT DU DERNIER BEBE

301-306

307: A suprimer?

310 (rev): Comment avez-vous été reçue par le personnel du centre de Santé (ou à l'hôpital ou centre de maternité)? Très bien, assez bien, pas très bien, mal reçue.

308 et 309: Utiliser l'information pour??

310 (rev): Combien de fois par heure... (Y-a-t-il un protocol précis? Si non, supprimer?)

311 (rev): Avez-vous eu un ou plusieurs examens gynécologiques...

312: (Y-a-t-il un protocol précis -- si non, supprimer?)

313

325

326 (rev.): Combien de minutes avant l'accouchement avez-vous été ----- (Comment utilizer?? - Supprimer?)

327-330

314: ...Autres agents (précisez): _____

315 et 316: (En Anglais: Unclear if the answers would be circled only if they were the people who came or if they were authorized, "in principle", to come. Skip #316, possibly, and ask instead whether it's important to the respondent to be allowed to have someone accompany her.

317: Lire les choix? (???? "forceps")

318-319

320 (rev) A la naissance, le bébé, était-il:
Très petit?
Petit?
Moyen?
Grand?

(Si possible, combien de semaines de gestation? ou combien de semaines avait-il à la naissance?)

321

322: Autres (précisez) (Comment utilizer les données?)

323 (rev): Y a-t-il eu des complications pour vous, la mère?

324: Autres (précisez) (Comment utilizer les données?)

neuf: Vous a-t-on référé à un autre centre ou hopital après l'accouchement?

neuf: Combien de minutes après l'accouchement?

neuf: (comme 327, 328, 329, 330)

Questions sur l'allaitement maternel:

(METTRE APRES QUESTION #330):

neuf	Combien de temps après l'accouchement êtes-vous restée au centre de Santé (ou à l'hôpital ou la maternité)?	. . . . . Jours . . . . . .minutes Ne sait pas 9

335	Le bébé a-t-il été allaité?	Oui . . . . . 1 Non 0
336 (rev) OMS Fac Ind. #6	Combien de temps après l'accouchement avez-vous allaité votre enfant pour la premiére fois?	Dans la première heure . . . . . 1 Dans les quelques premières heures . . . . . 2 Dans la première journée . . . . . 3 Plus d'une journée . . . . . 4 Ne sais pas 9
340 (rev)	Depuis sa naissance, et avant votre sortie de l'hôpital ou de centre de Santé, a-t-on donné quelque chose à boire ou à manger à votre enfant autre que le lait maternel? (vous même ou le personnel en charge)?	Oui . . . . . 1 Non . . . . . 0 Ne sait pas 9
341 (rev) OMS Fac. Ind. #1	A-t-on donné à votre enfant: (Lire la liste:)	Des vitamines, suppléments minéreaux, medicaments? . . . . . 1 De l'eau? . . . . . 2 De l'eau sucrée ou arômatisée? . . . . . 3 Une préparation pour nourrissons (une formule)? . 4 Du lait en boîte, en poudre, ou fais? . . . . . 5 De la bouillie de sorgho? . . . . . 6 Autre (précisez): . . . . .
342 (rev) OMS Fac. Ind. #3	Depuis sa naissance mais avant votre sortie, a-t-on donné à votre dernier bébé quelque chose à boire dans un biberon? (vous-même ou le personnel en charge).	Oui . . . . . 1 Non . . . . . 0 Ne sait pas 9
343 (rev) OMS Fac. Ind. # opt.2	Depuis sa naissance mais avant vorte sortie, a-t-on donné à votre dernier bébé une sucette ou tétine? (vous-même ou le personnel en charge).	Oui . . . . . 1 Non . . . . . 0 Ne sait pas 9
neuf OMS Fac. Ind. #4	Votre dernier bébé est-il resté avec vous dans votre chambre/lit/ ou près de votre lit, tout le temps que vous étiez au centre de Santé (l'hôpital ou la maternité)?	Oui . . . . . 1 Non . . . . . 0 Ne sait pas 9
neuf OMS Fac. Ind. #4	Combien de temps après sa naissance votre dernier bébé, a-t-il commencé à rester avec vous dans votre chambre/lit/ ou près de votre lit?	Après moins d'une heure? . . . . . 1 Après plus d'une heure? . . . . . 2 Ne sait pas 9
331 (rev)	Le personnel vous a-t-ils donné des conseils après l'accouchement et avant que votre sortie?	Oui . . . . . 1 Non 0

334 (rev)	Le personnel vous a-t-il donné des conseils sur: (Lire la liste:)	Les soins du bébé? . . . . . 1 Les soins de la mère? . . . . . 2 La nutrition de la mère? . . . . . 3 L'importance de l'allaitement exclusif jusqu'a 4 ou 6 mois? . . . . . 4 Comment exprimer lait à la main si vous êtes séparée du bèbè? . . . . . 5 La relation entre la fréquence d'allaiter et la quantité de lait produit? . . . . . 6 La méthode de planification familiale? . . . . . 7 L'allaitement exclusif comme méthode de planification familiale pendant les 6 primiers mois? 8 Autres (précisez): . . . . .

SUPRIMER #332, 333, 337, 338, 339

PASSEZ A 401

A DOMICILE:

Questions sur l'allaitement maternel:

334, 335 et 348: (En Anglais: unclear if asking if kept mother company during the labor or acted as a TBA ...344 and 348 worded pretty much the same. Need to work more on wording so indicates who helps delivery baby and how -- may be several people)

346: (Y-a-t'il un protocole ou standard? Si non, suprimer ou réviser.)

355: Etes...Delivrance? Pourquoi?

356 (rev): Combien de minutes, après ou avant l'accouchement (Suprimer, si il sera difficile à analyzer.)

357

358 (rev): Distance entre le domicile et la formation?

359 - 360

347 - 350

351 (rev): A sa naissance, le bébé était-il:
Tres petit?
Petit?
Moyen?
Grand?

Si possible, temps de gestation? ou combien de semaines le bébé avait-il à la naissance?

352 - 353

353 (deuxieme 353) (rev): Y a-t-il eu des complications pour vous, la mère?

354

neuf: Etes-vous allée à un centre de Santé ou à un hôpital après l'accouchement?

neuf: Combien de minutes après l'accouchement?

20

neuf: Comme #357

neuf: Distance entre la domicile et la formation

neuf: Comme #359

neuf: Comme #360

Questions sur l'attaitement maternel:

365	Le bébé a-t-il été allaité?	Oui . . . . . 1 Non 0
366 (rev) OMS Fac. Ind. #6	Combien de temps après l'accouchement avez-vous allaitez votre enfant pour la première temps?	Moins d'une heure après l'accouchement . . . . . 1 Quelques heures après l'accouchement . . . . . 2 Moins d'une journée après l'accouchement . . . . . 3 Plus d'une journée après l'accouchement . . . . . 4 Ne sais pas 9
370 (rev)	Pendant les deux premiers jours de sa vie, avez vous, l'acccoucheuse ou quelqu'un d'autre donné à votre enfant quelque chose à boire ou à manger autre que le lait maternel?	Oui . . . . . 1 Non . . . . . 0 Ne sait pas 9
371 (rev) OMS Fac. Ind. #1	A-t-on donné à votre enfant? (Lire la liste:)	Des vitamines, suppléments minéraux, médicaments?1 De l'eau? . . . . . 2 De l'eau sucrée ou aromatisée? . . . . . 3 Du thé ou des tisanes? . . . . . 5 Une préparation pour nourrissons (formule)? . . . . 6 Du lait en boîte, en poudre, ou frais? . . . . . 7 De la bouillie de sorgho? . . . . . 8 Autres (précisez): . . . . .
372 (rev) OMS Fac. Ind. #3	Pendant les deux primiers jours de sa vie, a-t-on donné à votre enfant quelque chose à boire dans un biberon? (vous-même, l'accoucheuse ou le personnel en charge)	Oui . . . . . 1 Non . . . . . 0 Ne sait pas 9
373 (rev) OMS Fac. Ind. # opt. 2	Pendant les deux primiers jours de sa vie, a-t-on donné une sucette ou une tétine à votre bébé? (vous-même, l'accoucheuse ou le personnel)	Oui . . . . . 1 Non . . . . . 0 Ne sait pas 9
362 (rev)	Avez vous reçu des conseils de l'accoucheuse traditionelle dans les deux jours après la naissance de votre bébé?	Oui . . . . . 1 Non . . . . . 0 Ne sait pas 9

364 (rev)	Vous a-t-elle donné des conseils sur: (Lire la liste:)	Les soins du bébé? . . . . . 1 Les soins de la mère? . . . . . 2 La nutrition de la mère? . . . . . 3 L'importance de l'allaitement exclusif jusqu'a 4 ou 6 mois? . . . . . 4 Comment exprimer lait à la main si vous êtes séparée du bèbè? . . . . . 5 La relation entre la fréquence d'allaiter et la quantité de lait produit? . . . . . 6 La méthode de planification familiale? . . . . . 7 L'allaitement exclusif comme méthode de planification familiale pendant les 6 primiers mois? 8 Autres (précisez): . . . . .

SUPRIMER QUESTIONS #362 - 363 et 367 - 369.

UTILISATION DES SOINS DANS LA PERIODE POSTNATALE POUR LA DERNIERE NAISSANCE

401 neuf	Dans les ?? semaines après la naissance de votre dernier bébé, êtes-vous allée au centre de Santé (ou à l'hôpital ou la maternité) pour une ou plusieurs visites?	Oui . . . . . 1 Non 0
402 neuf	Combien de fois êtes-vous allée au centre de Santé (ou à l'hôpital ou la maternité) pour les visites durant cette période?	. . . . . 1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . >4
403 neuf	Pourquoi êtes-vous allée au centre de Santé (ou à l'hôpital ou la maternité) pendant cette période?	Vaccinations . . . . . 1 Consultation sur nourrisson . . . . . 2 Soins du bébé . . . . . 3 Soins de la mère . . . . . 4 Planification familiale . . . . . 5 Autres: (précisez:) . . . . .
404 neuf	Pendant ces visites, qu'a fait le personnel lorsqu'il a examiné votre bébé?	Il a pesé le bébé? . . . . . 1 Il a demandé comment vous nourrissiez votre bébé? 2 Il a demandé si vous aviez des problèmes avec l'allaitement maternel? . . . . . 3 Il vous a dit de donner le lait maternel exclusif pendant les 6 premiers mois? . . . . . 4 Il a discuté quels aliments donner à votre enfant après les 6 premiers mois? . . . . . 5 (Autres questions sulr la planification familiale, les soins du bébé, etc.)
405 neuf	Lorsque le personnel vous a examiné, vous a-t-il parlé des choses suivantes:	Ce qu'il faut manger quand vous allaitez? . . . . . 1 Si vous aviez des problèmes avec vos seins? . . . . 2 (Autres questions sur la planification familiale, soins de mère, etc.)

QUESTIONS SUR LE PLANIFICATION FAMILIALE?

ANNEX C

FACILITY-BASED INSTRUMENTS –

SERVICE QUALITY CHECKLISTS

(BREASTFEEDING-RELATED COMPONENT)

RIM PROJECT SERVICE QUALITY CHECKLIST:

ANTENATAL CARE[4]
(Breastfeeding Component)

Key: 0 = Not done, 1 = Partially or incorrectly completed, 2 = Fully and correctly completed, DK = Don't know

REPRODUCTIVE HISTORY

Did the service provider update information about the following:

#. Past and current breastfeeding and any problems? . . . . . 0 1 2 DK
#. Mother breastfed? . . . . . 0 1 2 DK
#. Breast changes during pregnancy? . . . . . 0 1 2 DK
#. Previous breast surgery? . . . . . 0 1 2 DK

PHYSICAL EXAM

Did the service provider:

#. Examine breasts? . . . . . 0 1 2 DK
(Key points: surgical scars, inverted nipples, breast shape, masses)
#. Assess woman's nutritional status? . . . . . 0 1 2 DK
(Key points: Assess for nutritional risk (i.e. underweight, very overweight, inadequate weight gain, anemia, metobolic disease))

COUNSELING

Breastfeeding: Did the service provider:

#. Ask how woman plans to feed her baby? . . . . . 0 1 2 DK
Ask what she has heard (or her opinion is) about breastfeeding? . . . . 0 1 2 DK
Ask what concerns she has about breastfeeding, if any, and address them? . . . . . 0 1 2 DK
#. Discuss (or ask about) at least 2 benefits of breastfeeding? . . . . . 0 1 2 DK
(Key points: Nutritional advantages, protection against infection, bonding, health benefits for mother)
#. Discuss importance of feeding on demand & effects on supply? . . . . . 0 1 2 DK
#. Discuss at least 2 reasons for breastfeeding immediately after birth? . . . . . 0 1 2 DK
(Key points: colostrum, baby alert, assists with milk flow, helps prevent hemorrhaging of mother)
#. Discuss importance of rooming/bedding in with baby? . . . . . 0 1 2 DK

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[4] Adapted from DiPrete 1991.

(Key points: learning infant's cues, practicing breastfeeding, more frequent feeds)

#. Discuss at least 2 reasons for exclusive breastfeeding for 4 - 6 months? . . . . . 0 1 2 DK

(Key points: Best nutrition, greater protection against infection, lower risk of contamination (through bottles, other liquids), contraceptive effects)

Discuss at least 2 reasons why artificial nipples should not be used? . . . . . 0 1 2 DK

(Key points: Baby may develop artificial nipple preference, risk of contamination, difficult to clean)

Give locally-applicable nutrition advice to woman, if needed . . . . . 0 1 2 DK

INTERVIEW WITH PREGNANT WOMAN

#. Have you come for any other antenatal care visits? . . . . . Yes No

#. (If yes) How many? 1 2 3 4 5 6 7 8

#. (If yes) Did (the health provider) discuss breastfeeding with you during any of the other visits? . . . . . Yes No

#. (If yes) What aspects of breastfeeding did he/she discuss?

Past experience/problems 1
BF plans, this baby 2
Any BF concerns 3
Benefits of BF 4
Feeding on demand 5
BF immediately after birth 6
Importance of rooming-in 7
Exclusive BF, 4 - 6 months 8
Why artificial nipples shouldn't be used 9
Other: _____ 10

(Note: If mother reports that aspects of BF not covered in this visit were discussed during prior antenatal care visits, the scoring can be adjusted accordingly.)

RIM PROJECT SERVICE QUALITY CHECKLIST:

DELIVERY AND IMMEDIATE POSTPARTUM CARE[5]
(Breastfeeding Component)

Key: 0 = Not done, 1 = Partially or incorrectly completed, 2 = Fully and correctly completed, DK = Don't know

PROVIDE IMMEDIATE CARE FOR NEWBORN

Did the service provider:

#. Give the infant to the mother to breastfeed immediately (or at least within an hour of birth) and assist her, if necessary? . . . . . 0 1 2 DK

EDUCATION AT TIME OF BIRTH (OR BEFORE DISCHARGE)

(Note: Various educational components may be completed individually in delivery room or on ward, or during group sessions. Will need to determine when education likely to take place and observe at these times.)

Breastfeeding: Did the service provider:

#. Review mother's breastfeeding history and plans? . . . . . 0 1 2 DK
#. Ask what concerns she has about breastfeeding, if any, and address them? . . . . . 0 1 2 DK
#. Instruct mother on benefits of breastfeeding? . . . . . 0 1 2 DK
#. Tell mother to breastfeed immediately, giving colostrum? . . . . . 0 1 2 DK
#. Tell mother that increased milk flow will begin after 2-3 days? . . . . . 0 1 2 DK
#. Tell mother to breastfeed frequently, whenever infant is hungry (at least 8-12 times or more in 24 hours)? . . . . . 0 1 2 DK
#. Discuss how to tell if infant is hungry? . . . . . 0 1 2 DK
(Key points: Routing, searching, mouthing, in addition to crying)
#. Tell mother to feed the baby on one breast until baby comes off and then attempt to feed from other breast? . . . . . 0 1 2 DK
#. Tell mother to start feeding the next time with the other breast or the breast that feels fuller? . . . . . 0 1 2 DK
#. Tell mother to continue breastfeeding when she or her infant is ill and consult a care provider if concerned? . . . . . 0 1 2 DK
#. Advise mother about nipple cleanliness and care? . . . . . 0 1 2 DK
(Key points: Daily bathing with no special cleaning of nipples advised; soaps or lotions on nipples should be avoided; may apply small amounts of expressed breastmilk to nipples after feeding)
#. Demonstrate how to position and attach the baby for

---

[5] Adapted from DiPrete 1991.

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breastfeeding? . . . . . 0 1 2 DK
(Key points: Baby's body turned to mother, close, in alignment; mouth wide open, lips flanged; chin touching breast; more of areola below nipple in mouth; cheeks not drawn in; rhythmic burst-pause suckling and swallowing)

#. Demonstrate how to express breastmilk? . . . . . 0 1 2 DK
(Key points: Thumb on areola, fingers opposite; press inwards; do not slide fingers on skin; repeat press-release for several minutes; stimulate milk ejection reflex; rotate around nipple to compress all sinuses)

#. Discuss why mother should breastfeed exclusively (give no other food or drink) for 4 - 6 months? . . . . . 0 1 2 DK
(Key points: Best nutrition, greater protection against infection, contraceptive effects, lower risk of contamination (through bottles, other liquids), supplements lower milk supply)

#. Discuss with mother what she should eat to stay healthy during breastfeeding? . . . . . 0 1 2 DK

#. Instruct mother on signs of adequate milk intake (early weeks)? . . . . 0 1 2 DK
(Key points: Wet diapers (6 or more/24 hrs); bowel movements 4-8/day; content between feedings; weight gain, 4 - 7 ounces/week (average)

#. Instruct mother on how to tell if she needs help with breastfeeding? . . 0 1 2 DK
(Key points: Infrequent bowel movements first 1-2 weeks (<4 per 24 hrs.); baby not satisfied after BF, breast or nipple pain, other breast problems such as engorement, mastitis, blocked ducks, etc.)

#. Tell mother how to get help with breastfeeding if she needs it (return to clinic, other?) . . . . . 0 1 2 DK

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RIM PROJECT SERVICE QUALITY CHECKLIST

CARE DURING THE POSTNATAL PERIOD
(Breastfeeding Component)

TYPE OF POSTNATAL ENCOUNTER

Circle the number for the type of encounter being observed:

Vaccination (immunization) session (EPI) 1
Well-baby check-up, growth monitoring 2
Sick baby visit, ORT session 3
Nutrition session, food distribution session 4
Postpartum check-up for mother 5
Curative care for mother 6
Family planning (Covered in separate checklist) 7
Other (specify:) _____ 8

Key: 0 = Not done, 1 = Partially or incorrectly completed,
2 = Fully and correctly completed, DK = Don't know

PHYSICAL EXAM

(Note: This section could be adjusted either to cover each of the types of postnatal encounters above or to focus on key steps practitioner should follow if care is integrated.)

Did the service provider:

#. Examine baby? . . . . . 0 1 2 DK
(Key points: Check general appearance, hydration, oral-motor function and examine if suspected problem.)

#. Weigh baby and enter on growth chart? . . . . . 0 1 2 DK

#. Assess infant's nutritional status? . . . . . 0 1 2 DK
(Key points: Review weight for age and check for growth faltering, check for anemia, muscle wasting, edema, changes to hair texture and color, skin condition)

#. Weigh and measure mother (using standard techniques) and enter on chart? 0 1 2 DK

#. Assess mother's nutritional status? . . . . . 0 1 2 DK
(Key points: Underweight, very overweight, inadequate prenatal weight gain, rapid postpartum weight loss, anemia, metabolic disease)

#. Examine the mother's breasts/nipples? . . . . . 0 1 2 DK

#. Ask how mother is feeding the infant? . . . . . 0 1 2 DK

#. Review mother's current infant-feeding practices? . . . . . 0 1 2 DK
(Key points: Frequency and length of breastfeeds, baby's response, any other food/drink given and how, stool and urine output)

#. Ask about any feeding problems? . . . . . 0 1 2 DK
(Key points: Ask about pain, sore nipples, engorgement, fussy baby, etc.)

#. If breastfeeding problems, observe a breastfeed? . . . . . 0 1 2 DK
(Key points: General state of mother/infant (relaxed?, etc.), position, attachment, milk ejection reflex (let down), swallowing, mother's nipple shape and color after feed)

COUNSELING

Breastfeeding: Did the service provider:

#. Provide appropriate advice for feeding problems identified? . . . . . 0 1 2 DK
(Key points:
Insufficient milk: ?? - to be completed later)
Cracked or sore nipples: Proper attachment, nipple care, rule out thrush,
Engorgement: Proper attachment, express milk only as necessary for attachment
Breast infection: Rest, antibiotics, give frequent, effective feeds
Formula/bottle use: If using 4-6 oz./day can increase frequency of feeds and stop formula. If using more, will need to gradually reduce amount of formula as BF frequency gradually increases.

#. Encourage mother to exclusively breastfeed 4 - 6 months? . . . . . 0 1 2 DK

#. Tell mother no need to give additional water? . . . . . 0 1 2 DK

#. Give advice on proper diet for lactating woman? . . . . . 0 1 2 DK
(Key points: At least 3 meals daily, fluids every time BF, weight loss guidelines, importance of variety (extra protein foods, grains, fruits and vegetables), no routine food restrictions (beans, cabbage family, garlic, onions, etc.))

#. Teach mother how to express and store breastmilk? . . . . . 0 1 2 DK
(Key points: Thumb on areola, fingers opposite; press inwards; do not slide fingers on skin; repeat press-release for several minutes; stimulate milk ejection reflex; rotate around nipple to compress all sinuses)

Discuss mother's beliefs about food and nutrition for infant/child during first year of life . . . . . 0 1 2 DK

#. Explore mother's plans for supplemental feeding/weaning? . . . . . 0 1 2 DK

#. Discuss appropriate weaning foods and techniques? . . . . . 0 1 2 DK
(Key points: When, what, how to add non-milk foods; BF before giving solids at each feeding during first year.)

#. Tell mother where she can receive further infant feeding advice and support or arrange for follow-up visit, if necessary? . . . . . 0 1 2 DK

RIM PROJECT SERVICE QUALITY CHECKLIST:

FAMILY PLANNING SERVICES
(Breastfeeding Component)

Key: 0 = Not done, 1 = Partially or incorrectly completed,
2 = Fully and correctly completed, DK = Don't know

MEDICAL AND REPRODUCTIVE HISTORY (NEW CLIENTS)

Did the service provider:

#. Ask age of baby (or number weeks/months postpartum)? ..... 0 1 2 DK
#. Ask if she is breastfeeding? ..... 0 1 2 DK
#. Determine if she is exclusively breastfeeding? ..... 0 1 2 DK

DETERMINE METHOD

Did the service provider:

#. Describe contraceptive options to the client?

Pill 1
IUD 2
Injections 3
Norplant 4
Diaphragm, foam, jelly 5
Condom 6
Lactation Amenorrhea Method (LAM) 7
Female sterilization 8
Male sterilization 9
Rhythm, periodic abstinence 10
Withdrawal 11
Other (describe): _____ 12

(Note: List to be adjusted, depending on local availability of various options, methods provider authorized to discuss)

#. (If breastfeeding) Describe what methods are indicated/contraindicated while breastfeeding and why? ..... 0 1 2 DK
(Key point: If BF, choice of LAM (if meet criteria), barrier methods, natural family planning, IUD, progesterone-only pills - not combined hormonal contraceptives, as estrogen may inhibit milk production)

COUNSELING

Did the service provider:

#. (If the client is breastfeeding), describe the contraceptive effects of breastfeeding and added protection from exclusive breastfeeding? . . . . . 0 1 2 DK

#. Describe guidelines for LAM (if client planning to use it?) . . . . . 0 1 2 DK
(Key points: Baby must be less than 6 months, mother amenorrheic (no period) and exclusively breastfeeding)

ANNEX D

EXIT SURVEY OF MOTHERS AFTER DELIVERY

AND SAMPLE BREASTFEEDING INDICATORS FROM WHO

SAMPLE DATA COLLECTION INSTRUMENT FOR FACILITIES WHERE INFANTS ARE DELIVERED

This instrument is adapted from the questionnaire provided in the WHO/UNICEF document, "Indicators for Assessing Health Facility Practices that Affect Breastfeeding, Report of the Joint WHO/UNICEF Informal Interagency Meeting 9-10 June 1992, WHO, Geneva". It is designed to be used to question all mothers whose newborn infants are being discharged on the day(s) that the facility is visited. It provides the data needed for several key breastfeeding indicators for maternity services, including:

Ind. #1.	Exclusive breastfed by natural mother rate
Ind. #3.	Bottle-fed rate
Ind. #4.	Rooming-in rate
Ind. #5.	Breastfed rate
Ind. #6.	First time suckling rate
Ind. Opt. 2	Pacifier use rate

These are indicators for practices that have been shown, by research, to affect breastfeeding.

This version of the instrument suggests omitting the questions concerning whether the baby has received expressed breastmilk or been fed by a wet-nurse and whether staff has given the mother formula or other feeding supplies while in the maternity ward, since it is assumed that this is not usual practice in the facilities being studied. This information is used to calculate the additional indicators, Ind. #2 (Breastmilk substitutes and supplies received rate) and Ind. Opt. 1 (Exclusively breastmilk fed rate).

(Refer to the full report in English for the original of both the sample questions and the table summarizing how to calculate the indicators.)

Data can be collected on these indicators both before and after implementation of the Project. Other questions can be developed and included as part of the same instrument, if desired, to provide information for indicators in other areas of interest to the Project.

The sample instrument begins on the following page.

ECHANTILLON D'INSTRUMENT POUR LA COLLECTION DE DONNEES POUR LES SERVICES OU LES ENFANTS SONT MIS AU MONDE[6]

(Ces questions doivent êtres posées á toutes les mères avec des nouveaux nés renvoyés de l'institution le ou les jours de la visite).

Bonjour (ou Bonsoir). Je m'appelle (INDIQUEZ VOTRE NOM) et je travaille pour (INDIQUEZ LE NOM DU SERVICE ICI, ex: Ministère de la Santé, UNICEF, WHO, etc...). Nous aimerions apprendre plus sur certains aspects de votre séjour ici, surtout sur la façon dont votre enfant a été nourri et sur votre rapport avec le personnel. Ceci ne devrait prendre pas prendre plus que quelques minutes. Puis-je continuer?

1a. NOM DE L'INSTITUTION:

1b. NUMERO DU PATIENT:

1c. INTERVIEWER:

1d. DATE: jour/mois/année: _____/_____/_____

2. Votre bébé a combien de jours? _____jours

(S'il a moins d'1 jour) combien d'heures? ____ heures

3. Votre bébé, a-t-il été né par césarienne?
   Oui 1
   Non 2

4. Depuis hier á la même heure, avez vous allaité votre enfant?
   Oui 1 (sautez á la question #6)
   Non 2

5. Avez vous allaité votre enfant dans le passé?
   Oui 1
   Non 2 (sautez á la question #7)

6. Après combien de temps après la naissance avez vous allaité votre enfant pour la première fois: en l'espace d'une heure, après quelques heures, un jour, ou plus d'un jour?

   En l'espace d'une heure 1
   Après quelques heures 2
   En l'espace d'un jour 3
   Après plus d'un jour 4
   Ne sait pas/ne se souvient plus 5

(Omit) 7. Depuis sa naissance, votre bébé a-t-il reçu du lait maternel expressé ou a-t-il été allaité par une nourrice?
   Oui 1
   Non 2

8. Depuis sa naissance, vous, le personnel du service ou n'importe quelle autre personne, avez-vous nourri votre enfant avec quelque chose d'autre que le lait maternel?
   Oui 1

---

[6] Extrait de "Indicators for Health Care Facilities, Report of the joint WHO/UNICEF Informal Interagency Meeting, 9-10 June 1992, WHO, Geneva", (Annexes 2.1-2.4). World Health Organization and UNICEF (WHO/CDR/93.)

Non 2 (sautez á la question # 10)
Ne sait pas 9 (sautez á la question # 10)

9. Qu'a-t-on donné á l'enfant á manger ou á boire?

	Oui	Non
Vitamines, suppléments minéraux, médicaments 1	2	
Eau simple	1	2
Eau sucrée ou parfumée	1	2
Lait artificiel pour enfants	1	2
Lait en boîte, en poudre ou frais	1	2
Autre	1	2

10. Depuis hier à cette même heure, vous ou le personnel du service avez-vous nourri votre enfant avec un biberon?
Oui 1
Non 2

11. Vous ou le personnel du service avez-vous donné une sucette ou un pacificateur à votre enfant depuis qu'il est né?
Oui 1
Non 2

(Omit) 12. Depuis la naissance de votre enfant, ou depuis vos visites pré-natales, y-a-t-il un des membres du personnel qui vous a offert du lait artificiel pour enfant, ou du lait en boîte ou en poudre, ou des biberons, tétines, ou même des coupons pour ceux-ci?
Oui 1
Non 2

13. Votre bébé est-il resté avec vous tout le temps? (c'est á dire dans la même pièce, soit dans le même lit ou á côté).
Oui 1
Non 2 (Allez á la FIN du questionnaire)

14. A-t-on permis á votre enfant de rester avec vous (même pièce, lit ou á côté de vous) dans la première heure après sa naissance?
Oui 1
Non 2 (Allez á la FIN du questionnaire).

15. Votre bébé a-t-il été séparé de vous pour plus d'une heure au cours de votre séjour á l'hôpital?
Oui 1
Non 2 (allez à la FIN du questionnaire)

FIN DE QUESTIONNAIRE: Merci beaucoup pour votre temps et coopération!

ANNEX E

SAMPLE QUESTIONS FOR BREASTFEEDING FOCUS GROUP DISCUSSIONS AND GUIDE FOR FOCUS GROUP DEVELOPMENT

SAMPLE QUESTIONS FOR BREASTFEEDING FOCUS GROUP DISCUSSIONS

Introduction

A series of potential questions for focus groups related to breastfeeding are listed on the next page. More questions are listed than could comfortably (and productively) be explored in one focus group session. A small set of questions can be selected, or this larger range of topics can be covered in more than one session.

Questions selected may depend on such considerations as:

1) which questions probe areas where community and individual views are least understood;

2) which questions focus on beliefs and practices most likely to be either very beneficial or harmful to the mother or child; and

3) which questions focus on knowledge, attitudes and/or practices the health system and staff wants to either reinforce or to change.

Questions that <u>may</u> be particularly useful to explore within the Project areas are noted with an asterisk (*). Questions, of course, can be revised or adapted, as most appropriate.

Focus group discussions should be held with homogeneous groups of individuals, if possible. Discussions, for example, could be held with:

- Mothers with young children
- Young women who have not yet had children
- Older women
- Men
- Service providers of various types in health facility
- Traditional birth attendants

Each of the above groups may provide quite useful information on infant feeding beliefs and practices. Holding separate discussion groups will make it possible to determine what the major differences are. The most appropriate questions for various groups will vary somewhat, as well.

Following the list of questions, a quite useful article in French on focus group discussions is attached, which reviews how to prepare for and run a useful session.

BREASTFEEDING FOCUS GROUP DISCUSSIONS - POTENTIAL QUESTIONS

What are the benefits of breastfeeding?

What are the disadvantages of breastfeeding?

* Do babies that are breastfed have a different chance of sickness or death than babies that are bottlefed? Greater or less? Why?

Is infant formula better, worse, or about equally good to give to a baby? Why?

* If you could afford infant formula, would you want to give it instead of breastmilk? Why or why not?

* Is it good to give breastfeeding babies bottles once in a while? Why or why not?

Is it good to give breastfeeding babies pacifiers? Why or why not?

* How soon after birth do mothers usually give the first breastfeed? Why?

* Is it good to give the infant the colostrum that comes from the breast in the first days, or wait until the regular milk comes in? Why?

* When <u>should</u> breastfeeding start? Why?

If a mother delivers in a health center, hospital, or maternity center, is it best for the baby to be with her after the birth or in a nursery? Why? What is the usual practice in local health facilities?

Should an infant be breastfed on a set schedule or whenever he or she wants to nurse? Why?

* What problems with breastfeeding have women in the community experienced? What are the causes of the problems? How can they be solved?

* What are the causes of insufficient milk? What can be done about it?

Is there anything a woman shouldn't eat or drink, if she is breastfeeding? Why?

Is there anything a woman shouldn't do, if she is breastfeeding? Why?

What are the ways other family members (husband or father of baby, mother, mother-in-law, other children) help with infant feeding?

Is it ever good for a baby to be breastfed by a woman other than his or her own mother? Why or why not?

Should a mother breastfeed in public? Why or why not?

* How long (how many months or years) should a baby be breastfed?

* What difficulties cause some women to stop breastfeeding sooner? What solutions, if any, can you suggest to solve these various difficulties?

  What are the reasons, if any, that a mother should stop breastfeeding?

* Should a mother continue breastfeeding or stop when her baby has diarrhea? Why?

* Do first time mothers ever need advice or help with breastfeeding? If so, what types of advice or help are usually needed? Who usually gives it to them?

  Do staff at the health center or hospital ever give help or advice about breastfeeding? What types of help or advice do they most often give? Is it usually helpful or not?

* How soon should a baby start to receive liquids other than breastmilk? Why? What liquids should the baby be given? Why?

* When should a baby start receiving semi-solid or solid foods? What weaning foods are best? Why? How should they be prepared?

* What difficulties do women face in preparing and feeding their infant healthy weaning foods?

* Is "exclusive" breastfeeding (i.e., giving breastmilk and nothing else up to a certain age, a good practice or not? Why or why not? If good, up to what age?

* Do you think breastfeeding protects a mother against pregnancy? If so, for how long? Can breastfeeding be used as an effective contraceptive method? Why or why not? If effective, what are the rules for using it as a method?

* If a mother goes back to work when her infant is two or three months old and has to leave her infant at home, how should the infant be fed? What are the alternatives? Which are better and why?

* Do women ever express their breastmilk? (i.e., remove their breastmilk manually or with a pump?) Why or why not?

  How long can breastmilk be stored without refrigeration (at normal temperatures), without spoiling?

* Should a mother who knows she has AIDS breastfeed her baby? Why or why not?

From: Kidima, L., S. Scrimshaw, and E. Hurtado, "Methode d'Evaluation Rapide pour la Nutrition les Soins de Santé Primaires, Approche anthropologique pour une plus grande efficacité de programmes", Centre d'Etudes Latino-Americaine, UCLA, Series de Consultation Tome 11, 1990.

3 Groupes de discussion

Les interviews de groupe de discussion ou sessions exploratoires en groupe sont une technique de recherche qualitative fréquemment utilisée en sciences sociales. Une session avec un groupe de discussion est une consultation d'un petit groupe de participants (six à douze personnes) où ceux-ci, guidés par un modérateur, parlent librement et spontanément sur des thèmes considérés importants pour la recherche. Les participants sont choisis parmi un groupe cible dont les opinions et les idées offrent un intérêt pour la recherche. Généralement, plus d'une session est nécessaire pour assurer une bonne représentativité. Les sessions peuvent être conduites avec des sous-groupes variés, prélevés dans la population à étudier. Les participants peuvent être recrutés au hasard et brièvement interviewés pour déterminer s'ils répondent aux critères du groupe. Dans certaines cultures, particulièrement en Inde et en Afrique, les groupes de discussion se forment sans planification préalable car les voisins se joignent aux interviews spontanément. Il est conseillé de ne pas combattre cette tendance naturelle. Il faut au contraire l'exploiter et travailler avec ces groupes de discussion spontanés.

Les groupes de discussion peuvent être utilisés dans une étude du comportement relatif à la préservation et au rétablissement de la santé dans les buts suivants:

1. Clarifier les objectifs de la recherche et formuler les questions nécessaires pour l'interview formelle.
2. Compléter les informations sur les connaissances, les croyances, les attitudes et les perceptions de la communauté en ce qui concerne la santé et les ressources médicales.
3. Développer des hypothèses de recherche pour recherche ultérieure.
4. Développer un vocabulaire pour les programmes d'éducation sanitaire.

Un groupe de discussion type pour ce genre de recherche comprendra les dispensateurs de soins, le personnel des centres de soins, les agents de santé en milieu rural, les sages-femmes, les pharmaciens ou les mères d'enfants de moins de cinq ans.

La réunion du groupe de discussion est en général enregistrée sur bande magnétique bien qu'un observateur (le rapporteur) prenne des notes sur la discussion. La conversation est ouverte à tous: chaque participant a l'occasion de parler, de poser des questions à d'autres participants et de répondre aux questions d'autres participants, y compris le modérateur. L'interaction entre les participants est stimulée par la discussion des thèmes variés relatifs à la recherche. Le modérateur contrôle la session de façon à ce que tous les sujets d'intérêts soient couverts.

Une réunion de groupe de discussion dure en général jusqu'à une heure et demie. En général, les premières sessions sont plus longues que les suivantes parce que tous les renseignements obtenus sont nouveaux. Par la suite, le modérateur pourra avancer plus vite sur les points déjà couverts par d'autres groupes quand il est clair que tous les groupes sont du même avis. Le nombre de sessions à tenir avec des groupes de discussion dépend des besoins et des ressources du projet ainsi que de leur nécessité (de nouvelles données font-elles jour; y a-t-il encore des divergences de vues entre différents groupes de la communauté).

La réunion doit avoir lieu dans un local où les participants se sentent à l'aise pour parler ouvertement. Dans l'intérêt de la recherche, ce local doit être neutre. Par exemple, le centre de soins de la communauté n'est pas un endroit indiqué pour une réunion où l'on va parler des croyances locales ou de l'usage d'autres ressources en matière de soins. La paroisse ou le bâtiment de l'administration municipale seront plus appropriés.

PREPARATION D'UNE SESSION AVEC LE GROUPE DE DISCUSSION

Pour que la session soit la plus productive possible, les participants seront de même sexe, de même

groupe d'âge et de même classe socio-économique (ethnie, situation de famille, niveau éducatif, etc.). Les invitations doivent être distribuées une semaine ou plusieurs jours à l'avance. Bien que cela ne soit pas toujours faisable, le recrutement des participants par échantillonnage au hasard reste la méthode de choix. On pourra procéder selon la marche à suivre ci-après pour inviter les participants:

1. Parler de quelque chose qui peut intéresser le participant potentiel (les enfants, le climat, le marché, par exemple).
2. Lui parler de l'institution qui finance l'étude et du but général de la visite à la communauté en employant un ton sincère.
3. Expliquer la nature de la réunion prévue et inviter la personne à participer avec des voisins et d'autres personnes dans la communauté. Ne pas indiquer spécifiquement le sujet de la réunion d'avance. Par contre, mentionner le nom de personnes qui ont déjà accepté de participer (sauf dans le cas où les participants ne se connaissent pas, évidemment).
4. Confirmer la date, l'heure et l'endroit de la réunion, sa durée et mentionner que des rafraîchissements seront servis.
5. Si la personne ne veut pas ou ne peut pas participer, insister sur l'importance de la contribution de chacun. Si la personne persiste à refuser, la remercier et partir.
6. Si la personne est intéressée, confirmer le jour, l'heure, l'endroit et souligner brièvement l'importance de sa participation ainsi que de sa ponctualité, pour ne pas faire attendre les autres.

Le modérateur

Le modérateur utilise un guide ou plan de discussion pour contrôler la discussion et ne pas la laisser s'égarer. Le guide contient, entre autres, les objectifs de la recherche et comprend des questions ouvertes d'ordre général (par exemple, «Que font les gens ici?» au lieu de «Que faites-vous?»). Voir l'exemple de guide ci-dessous.

Les points ci-dessous décrivent le rôle du modérateur.

1. Il introduit les sujets de discussion. Le modérateur n'a pas besoin d'être un expert sur chaque sujet discuté, mais il devra le connaître suffisamment bien pour pouvoir poser des questions pertinentes. Le modérateur ne doit pas donner l'impression d'être un expert. Dès le départ, il adopte une approche enthousiaste pour aider à mettre les participants à l'aise. Il veille à garder le sens de l'humour.

Exemple de guide de discussion pour un groupe de discussion sur l'Immunisation

1. Que savez-vous sur l'immunisation?
2. Quel bien avez-vous entendu de l'immunisation?
3. Qu'en pensez-vous vous-même?
4. Quel mal avez-vous entendu de l'immunisation?
5. Qu'en pensez-vous vous-même?
6. Etes-vous déjà venu ici pour vous faire vacciner? Quand êtes-vous venu pour la dernière fois?
7. Pouvez-vous raconter ce qui s'est passé?
8. Qu'est-ce que vous avez aimé le plus dans ce programme de vaccination?
9. Qu'est-ce que vous avez aimé le moins dans ce programme de vaccination?
10. Pourquoi pensez-vous que les mères d'ici n'amènent pas leurs enfants au dispensaire?
11. A votre avis, que faudrait-il que le programme dise pour que les mères amènent leurs enfants à se faire vacciner?
12. Qui devrait le dire aux mères pour qu'elles viennent?
13. Dans cette communauté, quel moyen serait à votre avis le meilleur pour communiquer cela?
14. Pourquoi recommandez-vous ce moyen?
15. Pourquoi fait-on ces campagnes de vaccination, à votre avis?
16. Quelles sont les vaccinations offertes lors de ces campagnes?
17. Quelles maladies peuvent être évitées avec ces vaccinations? (MONTRER LES LOGOTYPES DU PROGRAMME DE VACCINATION).
18. Lesquels de ces motifs préférez-vous pour annoncer le programme?
19. Pourquoi?

---

2. Il contrôle le groupe et ne se laisse pas contrôler par lui. Il pose les questions appropriées et réagit de manière neutre et pertinente aux commentaires des participants. Il souligne, pour les participants, qu'il n'y a pas de bonne ni de mauvaise réponse. Ses gestes et autres formes de communication non verbale (par exemple, un signe de tête) ne doivent pas suggérer qu'il est d'accord ou non avec les commentaires des participants. Il doit éviter de réagir à la discussion ou d'exprimer des opinions personnelles qui pourraient influencer les participants. ...
3. Il observe les participants et se fait une idée de leur niveau de partipation et de réaction. Il les encourage à tous participer et ne permet pas que quelques individus monopolisent la discussion. (Consulter les techniques d'encadrement de groupes discutées page 00.)
4. Il écoute attentivement afin de faire progresser la discussion point par point et de toujours trouver un lien entre les commentaires des participants et la question suivante. (Par exemple, «Ce que vous avez dit concernant la longue attente à la clinique me rappelle une autre question que je voulais poser. Où allez-vous si vous n'avez pas le temps d'aller à la clinique?») Eviter de tourner la discussion en une session questions-réponses ou

intervieweur-interviewé; il faut au contraire encourager une discussion d'égal à égal pour que les participants puissent communiquer entre eux au point d'oublier qu'il y a un modérateur.

5. Il établit un bon rapport avec les participants et gagne leur confiance pour pouvoir poser des questions plus approfondies lorsque leurs réponses et commentaires l'exigent.
6. Il sympathise avec les participants et fait un effort pour comprendre non seulement ce qu'ils disent mais aussi ce que cela signifie pour eux.
7. Il est flexible et ouvert aux suggestions, aux changements et aux interruptions et même au manque de participation.
8. Il contrôle subtilement le temps alloué à chaque question et à la réunion en général, sans donner l'impression de «regarder l'heure» ou d'accélérer le rythme.
9. Il contrôle le rythme de la réunion. Celle-ci ne doit par exemple pas s'étendre sur des sujets déjà couverts par d'autres groupes si le modérateur juge que le groupe en session est du même avis que ceux-ci. Tous nouveaux éléments ou opinions doivent cependant être discutés en profondeur. La première session du groupe de discussion est d'ailleurs en général la plus longue pour cette raison.
10. Il observe toute communication non verbale et y réagit conformément. Par exemple, la façon de s'asseoir d'un individu, ses gestes et d'autres indications remplacent la communication verbale et peuvent suggérer l'impatience, la tranquilité, la fatigue, l'ennui, l'anxiété, etc.
11. Il est conscient du ton de sa voix. Un ton trop affirmé, aggressif ou impératif peut intimider les participants, surtout quand il s'agit de questions approfondies. Le participant peut avoir l'impression d'être attaqué si le ton de la voix ne semble pas très amical.

Le rapporteur

Le rapporteur est d'abord là en tant qu'observateur pendant la réunion du groupe de discussion. Sa responsabilité est de prendre notes sur la discusion. Les notes doivent inclure les points suivants (voir le modèle pour les notes du rapporteur ci-après).

1. La date de la réunion, l'heure où elle a commencé et celle où elle s'est terminée.
2. Le nom de la communauté et une brève description de celle-ci et tous autres renseignements relatifs aux activités des participants (la distance de la communauté à la plus grande ville ou unité politique, par exemple).
3. L'endroit où la réunion a lieu, une brève description de celui-ci et toutes indications sur la façon dont il peut affecter les participants (y a-t-il assez d'espace, est-il confortable, d'accès facile, par exemple).
4. Le nombre des participants et quelques données descriptives sur eux, comme leur sexe, leur âge approximatif et divers autres renseignements importants pour le projet de recherche (le nombre de femmes dont les enfants ont été ou n'ont pas été vaccinés, le nombre de femmes qui utilisent ou n'utilisent pas de méthode de planification des naissances, par exemple).
5. Une description générale de la dynamique du groupe, le niveau de participation, s'il y a un participant dominant, le niveau d'intérêt (fatigue, anxiété, ennui, etc.).
6. Les interruptions et distractions qui ont lieu pendant la réunion.
7. Ce qui fait rire les participants, ce qui les fait hésiter à répondre, comment la discussion se termine.
8. Les opinions des participants, en utilisant des phrases telles que: «la majorité des participants pense que ... mais Mme Buzika ... dit que le groupe est divisé également en deux; certains pensent que ...» Le rapporteur utilisera des guillemets pour citer les mots exacts utilisés par le participant. Les impressions personnelles et les observations seront notées entre parenthèses. L'enregistrement magnétique de la réunion servira à développer les notes prises pendant les sessions. (Le rapporteur est responsable du magnétophone).

Notes du rapporteur (page 1)

Date: Heure: Début:
Fin:
Durée:

Communauté:
Description brève:

Lieu de la réunion:
Description brève:
Nombre des participants: Hommes:
Femmes:
Total:

Nom et caractéristiques des participants (sexe, âge, etc.)
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Dynamique du groupe:

9. Le vocabulaire général des participants. Le rapporteur doit s'efforcer de noter les mots exacts du participant, dans la langue locale. (Il ne faut pas oublier que l'un des objectifs de la recherche est d'apprendre le plus d'expressions locales possible.)

Bien que ce soit la responsabilité du modérateur de diriger la réunion, le rapporteur peut intervenir, discrètement, surtout dans les situations suivantes:

1. Le modérateur peut occasionnellement ne pas entendre les commentaires d'une personne pendant qu'il en écoute une autre. Dans ce cas, le rapporteur peut dire, par exemple, «Madame Kabeya a signalé quelque chose que nous n'avons pas encore entendu. Pourriez-vous répéter ce que vous venez de dire, Mme Kabeya?»
2. Le rapporteur peut suggérer une nouvelle question ou un nouveau sujet important pour la recherche.
3. Dans le cas où le modérateur aurait omis une question du guide, le rapporteur peut le lui faire remarquer. (Le modérateur et le rapporteur doivent chacun avoir une copie du guide de discussion pendant la réunion.)
4. Le rapporteur notera si le modérateur a perdu le contrôle de la réunion.
5. Le rapporteur peut suggérer des moyens de rendre la discussion plus riche d'enseignement.
6. Le rapporteur peut aider le modérateur à résoudre les conflits internes.

SESSION AVEC LE GROUPE DE DISCUSSION

Avant la réunion

Le modérateur et le rapporteur doivent être les premiers à arriver sur les lieux de la réunion. Ils commenceront à parler de façon informelle avec les participants, ou avec les curieux qui ont pu s'assembler, au fur et à mesure qu'ils arrivent. Il faut profiter de cette période de temps pour apprendre le nom des personnes et en savoir davantage sur ce qui les intéressent. Généralement, la plupart éviteront d'«arriver le premier» et attendront de voir d'autres personnes arriver pour arriver à leur tour. Il faut donc donner l'impression qu'on est prêt à commencer.

Le modérateur doit s'assurer que l'arrangement des sièges encourage tous les participants à parler. Il est recommandé que les participants s'assoient en cercle, plus ou moins à même distance du modérateur. Le modérateur doit tout faire pour éviter des interruptions de l'extérieur une fois la réunion commencée. L'idéal serait que le modérateur et les participants soient de même sexe.

On aura besoin du matériel suivant: un magnétophone, des cassette vierges, des piles (pour les endroits sans électricité) et des guides de discussion.

Ouverture de la réunion

L'introduction à la réunion est un moment-clé car il détermine le ton et l'atmosphère de celle-ci. Au départ, le modérateur se montrera animé et loquace pour mettre les participants à l'aise. Lors de l'introduction, le modérateur veillera à procéder en incluant les éléments suivants:

1. Faire les présentations et expliquer le rôle du modérateur et du rapporteur.
2. Demander aux participants de donner leur nom (le nom de famille n'est pas nécessaire). Le modérateur veille à les apprendre rapidement et à les employer quand il s'adresse aux participants.
3. Expliquer que la réunion n'est pas un cours, mais plutôt un effort pour rassembler les avis et idées du groupe dans le but de les incorporer dans un programme de santé ou une campagne sanitaire. Le modérateur explique aussi que la réunion a été organisée pour entendre ce que les participants ont à dire et que ni lui ni le rapporteur ne sont des experts sur le sujet.
4. Faire remarquer que l'avis de tous les participants est important et que tous doivent se sentir libres d'exprimer ce qu'ils pensent des sujet abordés.
5. Expliquer qu'il n'y a que deux règles dans cette réunion: que la personne qui parle doit parler du sujet discuté et qu'une seule personne ne parle à la fois.
6. Commencer la réunion en posant à chaque participant une question d'intérêt général, qui n'a rien à voir avec l'objet de la réunion. De cette façon chacun a la chance de parler d'un sujet neutre avant le début de la réunion. (Par exemple, le modérateur peut demander combien d'enfants a chaque participant, depuis combien de temps chacun vit dans le village, etc.)

Techniques de gestion du groupe de discussion

Il existe plusieurs techniques faciles à apprendre et qui peuvent être appliquées à la gestion du groupe de discussion. Ces techniques sont particulièrement utiles pour déterminer les sujets à aborder et les questions spécifiques à poser.

Clarification.—La réponse donnée par un participant à une question peut être répétée sous forme de question pour clarification ou pour encourager les participants à s'étendre davantage sur le sujet. (Par exemple, «Pouvez-vous m'en dire plus à ce sujet ...?» ou «Que voulez-vous dire quand vous dites ...?»)

Substitution.—Une question peut être reformulée avec d'autres mots mais sans en modifier le sens original. Le modérateur doit veiller à ce que la ques-

tion reformulée ne suggère pas une réponse. (Par exemple, «Jusqu'à quel âge allaite-t-on les enfants ici?», «Pendant combien de temps allaitez-vous les enfants ici?»)

Réorientation.—Pour que la discussion reste animée et intéressante, on peut recourir à la technique de la réorientation. Le modérateur peut utiliser une réponse d'un participant ou répéter la question pour quelqu'un d'autre. (Par exemple, «Mme X, vous nous dites que vous allaitez jusqu'à ce que l'enfant ait six mois. Et vous Mme Y (celle-ci n'a pas encore donné son avis), vous allaitez vos enfants jusqu'à ce qu'ils aient quel âge?»)

L'expert.—Il est recommandé que le «spécialiste» ou l'«expert» (comme le dispensateur de soins, la sage-femme) ou une autre personne ayant une position d'autorité (comme le maire) ne soit pas présent aux réunions du groupe de discussion, à moins que la réunion n'ait été spécifiquement organisée pour les mettre en présence du groupe de discussion. Quoi qu'il en soit, si leur participation est inévitable, il faut leur expliquer avant la réunion que la meilleure façon pour eux de participer est d'écouter la discussion. Ils auront l'occasion de faire part de leur point de vue et conclusions avec le modérateur après la réunion.

Participant dominant.—Quand le groupe a un participant dominant, le modérateur devra essayer d'obtenir le plus d'informations possibles des autres participants. Il pourra aussi changer de sujet et éviter tout contact visuel avec celui-ci pour le décourager de parler. Si tout cela ne réussit pas, le modérateur pourra poliment faire la remarque que les autres doivent aussi avoir l'occasion de parler.

Participant réservé.—Pour encourager une personne à participer à la discussion, le modérateur orientera l'attention vers elle en l'appelant par son nom et en lui adressant des questions personnellement. Le modérateur établira un contact visuel pour l'encourager à contribuer davantage. Il pourra aussi demander au participant son point de vue sur ce qu'un autre participant vient de dire, ou résumer ce que le groupe a dit sur un sujet particulier.

Techniques supplémentaires.—Pour assurer une participation maximale du groupe, une technique efficace consiste à écrire le genre de renseignements désirés sur le sujet et à expliquer au groupe pourquoi ceux-ci sont nécessaires. Les participants seront heureux de pouvoir être utiles et reconnaîtront la valeur de leur expérience personnelle.

On pourra aussi utiliser des photos ou des images pour stimuler la discussion. Par exemple, on pourra montrer une photo d'enfant sous-alimenté et demander «Cet enfant, vous paraît-il en bonne santé? malade? Que devrait faire sa mère? Si elle était votre voisine, que lui conseilleriez-vous de faire?»

Des résultats d'une étude antérieure peuvent être présentés aux fins de discussion.

Fin de la réunion

Pour terminer la réunion du groupe de discussion, le modérateur doit:

1. Expliquer que la réunion va bientôt toucher à sa fin, demander aux participants de réfléchir sur les sujets abordés et leur demander l'un après l'autre s'ils ont d'autres commentaires. Les commentaires pertinents peuvent être approfondis.
2. Remercier les participants pour avoir exprimé leurs vues et réaffirmer que leurs idées sont d'une grande valeur et qu'elles seront utilisées dans la planification des programmes, la production de matériel éducatif, etc.
3. Ecouter si des commentaires supplémentaires sont faits pendant que les rafraîchissements sont servis (s'il y en a).

Après la session, le modérateur et le rapporteur se réunissent pour revoir et compléter les notes prises pendant la réunion.

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ANNEX F

REFERENCES

REFERENCES

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