

**JOINT HEALTH
FACILITY-COMMUNITY
PROBLEM-SOLVING PROCESS**

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Karabi Bhattacharyya, Sc.D.

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TABLE OF CONTENTS

ACRONYMS

EXECUTIVE SUMMARY	1
BACKGROUND	2
DESIGN OVERVIEW	2
Methods	5
Phase 1 - Building Partnerships	7
Phase 2 - Selecting 3-5 Emphasis Behaviors	10
Phase 3 - Exploring Reasons for the Behaviors	11
Phase 4 - Developing Intervention Strategies and Next Steps	16
RESULTS AND DISCUSSION	17
Indicators	17
PRIORITIES AND STRATEGIES	19
REVIEW OF THE PROCESS	19
NEXT STEPS	20

APPENDIXES

- Appendix A: List of participants
- Appendix B: Household survey Questionnaire
- Appendix C: Tabulation forms for household questionnaire
- Appendix D: One pagers on each behavior
- Appendix E: Evaluation of the Community Assessment and Training by Participants
- Appendix F: Action plan for Jerusalem Health Centre/Mutubaya/Chimtiko
- Appendix G: Detailed training curriculum

ACRONYMS

BASICS	Basic Support for Institutionalizing Child Survival
CHW	Community Health Worker
IEC	Information, Education, Communication
IMCI	Integrated Management for Childhood Illnesses
MOH	Ministry of Health
NGO	Nongovernmental Organization
ORS	Oral Rehydration Solution
RHF	Rehydration Fluid
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
USAID	United States Agency for International Development
ZCH	Zambia Child Health Project

EXECUTIVE SUMMARY

Purpose

The purpose of this trip was to test and implement a participatory approach to community assessment and to train health staff in the approach. The purpose of the assessment was for health facilities and the communities they serve to jointly identify maternal and child health problems and to work together to solve them. The process: 1) collect important information to identify health problems and serve as a baseline for monitoring the progress of solving those problems in two communities; and 2) promote and facilitate community involvement in the planning of both community and facility health activities which are critical to the sustainability of health programs.

Design and Methods

The process begins with a list of emphasis or key behaviors which have been shown scientifically to decrease child morbidity and mortality. The process uses the list of emphasis behaviors as a "menu" from which communities and health facilities jointly decide which of these behaviors are a priority and could be changed. This then forms the basis for the joint action plan. The methodology includes both participatory and qualitative methods with a structured household survey. The training was conducted over two weeks in a community, in four phases.

Field-testing

The process was conducted as a training of Ministry of Health staff in the methodology for two weeks, and included seven to eight days' fieldwork in two communities with a total of about 65 households in Chipata District, Eastern Province. A total of 14 people were trained, including health staff from the national level, three districts in the Eastern Province, and staff from one health facility. As a group, all four phases were completed. Plans have been made to conduct the process in two additional districts in the Eastern Province.

Results and Products

The information that is collected is used at several different levels. The health staff and community teams use the data immediately to develop community action plans for their community. The qualitative data can be used to develop communication materials that address a range of community situations. In Zambia, the process resulted in 1) community action plans for two villages; 2) a risk map showing indicators for each child under 2 years old; 3) trained staff at national, district, and health center levels (three districts).

BACKGROUND

One of the main “pillars” of the Zambian health reform is the promotion of “partnership.” However, the concept of partnership has not been operationalized and remains unclear. A few activities have taken place to promote partnership, but they have not been part of a larger strategic plan.

The first output of the Zambia Child Health Project (ZCH, the bilateral agreement between USAID and government of Zambia) is the establishment of partnership between health centers and the communities. The Central Board of Health has established guidelines for the formation of neighborhood committees to work with health centers, but there is currently little capacity to involve these committees in the development of health center work plans. The ZCH project is providing technical support to the community partnership initiative in two broad areas. First, through an NGO small grants program, NGOs will link with government health facilities to implement the six essential health thrusts identified by the MOH in Zambia. Secondly, the ZCH project will provide on-going support to the MOH at the central, regional, and district levels in implementing community partnership activities. The activity described in this report falls within this second aspect of ZCH support.

DESIGN OVERVIEW

The design of the community assessment responds to a number of trends in public health planning. Throughout the world, especially in Africa, there is a trend for planning that primary health care programs are decentralized to the district level and away from national, vertical disease control programs. Along with this increased decentralization, there is a trend towards “integration” of maternal and child health programs. More and more countries are implementing the “supermarket” approach in health facilities where all services are available every day instead of specifying certain days for immunization or for growth monitoring. This assessment is designed to be used by health staff at the district level and below and is integrated in that it addresses all the major causes of child morbidity and mortality.

Amidst the “epidemic” of formative research manuals, large-scale household surveys, and the debates over qualitative and quantitative methods, little attention has been given to developing tools which could be used by local-level health staff who often work with limited technical and financial resources. Health staff need assistance with how to form a working group with community representation, how to engage in a dialogue with communities to understand their needs and constraints, and to plan interventions that target the people most in need at the times when they are most in need. With the decentralization of planning and decisionmaking in a number of countries, it is even more urgent that health facility staff begin to engage the communities they serve in an on-going dialogue. The goal of the community assessment described here is for the health staff and the communities they serve to jointly identify and prioritize health problems and work together to solve them.

The important features of this assessment are that it:

- ☞ Focuses on a limited number of maternal and child health behaviors which are critical to the prevention and management of the most important causes of childhood morbidity and mortality.
- ☞ Uses an integrated household survey which measures indicators on all the major causes of childhood morbidity and mortality.
- ☞ Combines participatory and qualitative approaches with a quantitative survey.
- ☞ Is conducted by the MOH staff who are responsible for implementing health programs and a team of community volunteers; not an outside research team.
- ☞ Produces joint action plans for both the community and health facility, as well as household-level data.
- ☞ Balances activities imposed on the community by the MOH and requests from the community which fall outside the MOH domain (e.g. wells, roads) by using the emphasis behaviors as a “menu” to guide planning.
- ☞ Encourages community members and the health staff to analyze and use the information immediately.
- ☞ Teaches a simple methodology that does not require extensive time or resources so that it is replicable at the district level or below.
- ☞ Collects data that can be used at multiple levels: at the community level to develop an action plan; and at the district, zonal, regional, and project levels for project monitoring and evaluation.

The training workshop for the community assessment had four main objectives:

1. Develop a community implementation plan with full participation and consensus of communities.
2. Develop a community implementation plan based on primary health care behaviors which are documented to impact on maternal and child health.
3. Collect key indicators for monitoring and evaluation of community and household activities.

4. Build capacity of local staff and communities to develop and evaluate community programs.

Although all four objectives were equally important, the need to build local capacity heavily influenced the design and methodology of this approach. Every attempt was made to streamline the process in both time and resources. Hence, for example, the only materials required were copies of the household survey, a small notebook, and a pencil, and the results of the survey were all hand-tabulated. This is described in more detail below.

The process began with a list of emphasis behaviors (listed in the table below) which have been shown scientifically to decrease child morbidity and mortality.¹

¹For a complete discussion of the emphasis behaviors including the technical justification for their selection, see *Emphasis Behaviors in Child Survival: A Guide to Key Behaviors of the Caretakers of Young Children*, BASICS Technical Report, 1996.

Emphasis Behaviors for Maternal and Child Health

INFANT AND CHILD FEEDING PRACTICES

- Breastfeed exclusively for about six months
- From age 6–24 months, provide appropriate complementary feeding

IMMUNIZATION PRACTICES

- Take infant for measles vaccination as soon as possible after age 9 months
- Take infant for immunization even when infant is sick
- For pregnant women and women of childbearing age, seek tetanus toxoid vaccine at every opportunity

HOME HEALTH PRACTICES

Prevention

- For pregnant women, seek antenatal care at least two times during each pregnancy
- For women of childbearing age, use a modern method of contraception
- Wash hands with soap at appropriate times, and transport and store all drinking water in covered, narrow-necked water containers
- Use and maintain insecticide-treated nets
- For all pregnant women, take one daily or weekly iron tablet
- For all families, use iodized salt

Treatment

- Continue feeding and increase fluids during and after illness
- Administer treatment medications according to instructions
- Mix and administer ORS or appropriate home available fluid correctly

CARE SEEKING PRACTICES

- Seek appropriate care when the infant or child is recognized as being sick

The list of emphasis behaviors is used as a “menu” from which communities and health staff jointly decide which behaviors are a priority and could be changed. The selected behaviors then form the basis for the development of intervention strategies and a joint action plan.

Methods

The methodology includes both participatory and qualitative methods, with a structured household survey. For the qualitative and participatory procedures (public meeting, social mapping, free listing, matrix ranking, semi-structured interviews), a suggested checklist of topics or issues was provided which was modified both during the training and in the field. During the training, minor changes were made on the questionnaire and standard definitions were agreed upon.

Phase 1: *Identifying Partners and Building Partnerships* emphasizes the establishment of working relationships between the health staff and community team members. The health staff are introduced to the community through a public meeting. The community learns that we are here to listen to them when THEY draw a map of their community and diagram the community organizations.

Phase 2: *Selecting the Emphasis Behaviors* involves the use of a simple household survey which collects information on the key child health behaviors in households with children under 2 years old. The team then tabulates the data by hand. The behaviors shown to be at unacceptable levels by the survey are ranked by groups of men and women according to the importance of the behavior and the feasibility of changing the behavior. Based on the community ranking, three to five priority behaviors are selected.

Phase 3: *Exploring Reasons for the Behaviors* involves the use of a variety of participatory research techniques, including semi-structured interviews, seasonal calendars, and matrix ranking, to explore the reasons behind the practices of the three to five selected behaviors. For each behavior, there is a list of suggested topics and methods for understanding the behavior more fully.

Phase 4: *Developing Intervention Strategies* is based on the reasons why people are not doing the selected behaviors. The intervention strategies are suggested by community members and the health staff. During a public meeting, the action plan is developed for implementing the strategies. The action plan includes the identification of resource needs and allocation of responsibilities.

The following table provides an overview of the four phases:

Community Assessment At A Glance	
Phase	Activities/Procedures
Phase 1: Identifying Partners, Building Partnerships, and Making a Map	Logistics Finalization of forms, schedules
	Selection of focus community Visits to focus community Formation of community team
	Training in household survey PRA methods
	Public meeting Social mapping Free listing and ranking of child illnesses Team meeting
Phase 2: Selecting the Emphasis Behaviors	Household survey Hand tabulation Prioritize behaviors (3-5) based on indicators and health impact Matrix ranking / scoring Seasonal calendars Team meeting
Phase 3: Exploring the reasons for the behaviors	In-depth interviews Prepare for public meeting
Phase 4: Developing intervention strategies and next steps	Public meeting Team meeting
	Further analysis of data and experience Next steps in all districts

Phase 1 - Building Partnerships

The workshop was held in Chipata in the Eastern Province of Zambia. The district had selected Jerusalem Health Center to participate in this initial training activity. The community activities were carried out in Chimtiko and Mutubaya villages. The two villages are next to each other and about seven kilometers from Jerusalem Health Center.

The workshop participants included three people from various parts of the MOH based in Lusaka, two people each from Chipata, Chama, and Lundazi districts, and two people from Jerusalem Health Center. The full list of participants is attached in the appendix.

Workshop schedule

A detailed curriculum based on this workshop was written by Elizabeth Burleigh for use in future trainings. This is attached in the appendix since it describes the workshop in detail day by day.

The following table is an overview of the schedule.

Schedule	
Day and Date	Activities
Monday, January 13	<i>Morning</i> Overview of the ZCHP and community assessment Elements and purpose of participation <i>Afternoon</i> Discussion of emphasis behaviors Social mapping
Tuesday, January 14	<i>Morning</i> Semi-structured interviews Venn diagrams <i>Afternoon</i> Seasonal calendars Matrix ranking and scoring
Wednesday, January 15	Household survey review Practice household survey in pairs Judging the quality of information Forming groups Team contract Plan for next day
Thursday, January 16	<i>In community</i> Public meeting Social mapping Venn diagrams <i>In workshop</i> Preparation for household survey Listing and numbering of households
Friday, January 17	<i>In community</i> Finalization of social map Household survey
Saturday, January 18	<i>In workshop</i> Hand tabulation of survey results Calculation of indicators Selection of behaviors to present to the community Preparing for the community's selection of the behaviors
Sunday, January 19	Rest day

Monday, January 20	<i>In community</i> Using matrix scoring with community to select the behaviors
Tuesday, January 21	<i>In community</i> Exploring reasons for the behaviors: Matrix scoring Semi-structured interviews Analysis of the information collected
Wednesday, January 22	<i>In community</i> Developing an action plan Completing the risk map
Thursday, January 23	<i>In community</i> Public meeting to present action plan and risk map <i>In workshop</i> Workshop evaluation
Friday, January 24	Next steps in the community Next steps for other districts

Public meeting, social mapping, Venn diagrams

The first day in the focus communities was spent building rapport through informal conversations, and meetings with community leaders, the community team, and traditional healers. In addition, health facility staff and the community team were oriented to the assessment and their roles in the assessment. A meeting was held with as many people from the community as possible and facilitated using the suggested checklist².

Suggested public meeting checklist

- ◆ Introductions by everyone
- ◆ Explanation of purpose: Health facility trying to improve services, wants to understand community problems, wants to improve relations with the community, focus on child health
- ◆ Explanation of the need for ideas from all community members
- ◆ Explanation of what the community can expect from us, including confidentiality
- ◆ Introduction of community interviewers and district team, and discussion of their roles
- ◆ Overview of schedule while in village
- ◆ Setting of the time and place to meet at end of stay to present the information collected and develop an action plan

After the public meeting, two groups of men and two groups of women were formed to draw a social map and Venn diagram of their community. This allowed the outsiders to get an overview

² The checklists for all the qualitative and participatory procedures were suggestions and were modified by each team in the communities as necessary. Hence the actual checklists used by each team differed somewhat. Any significant deviations are mentioned in the text.

of the community, as well as to show the community members that we were interested in learning from them. After the map and Venn diagram was drawn on the ground, it was transferred to paper either by community members or the MOH team.

Suggested checklist for social mapping

- ◆ Overall layout of village
- ◆ Water sources
- ◆ Roads in and out of village, markets
- ◆ Main sources of health care and medicines
- ◆ Main ethnic groups and their location within the village
- ◆ Main socio-economic groups and their location within village, especially the very poor
- ◆ “Public goods,” such as schools, churches, mosques
- ◆ “Parts” or sections of the village
- ◆ Households with a child under 2 years old

Suggested checklist for Venn diagrams

- ◆ Community-based organizations—type and membership (initiation groups, funeral groups, development committees)
- ◆ Local political structures (elders, chiefs, peasant associations, elected officials)
- ◆ Outsiders who visit the community on a regular basis
- ◆ Religious groups
- ◆ Traditional healers, traditional birth attendants

Phase 2 - Selecting 3–5 Emphasis Behaviors

Household survey

From the social mapping, all the households with children under 2 years were identified. All households with a child under 2 were then interviewed (not a sample of households). The respondent was the primary caretaker of the child. The surveyors worked in pairs (based in part on language skills) to interview each mother of a young child.

The results of the survey were tabulated using the worksheets attached in the appendix. The results were then discussed as a group and the behaviors to be used in the matrix ranking were selected.

Matrix ranking

The behaviors that were considered unacceptable based on the results of the household survey were presented to groups of men and women (six to eight men or women in each group) and prioritized using matrix ranking. Matrix ranking is done on the ground using locally available materials as symbols for each behavior, and maize, sticks, or berries to rank the importance and feasibility of the behaviors. Based on the information from the matrix ranking, three to five of the emphasis behaviors are selected as priorities for action. The results of the matrix ranking is shown in the table below.

Matrix Ranking to Prioritize Behaviors (10=most important or most feasible)				
Behavior	Importance		Feasibility	
	Men	Women	Men	Women
*Family Planning	3	8	4	
Use of latrines	4	7		
Hand washing with soap	5	4		
*Improved feeding of sick children	10	10	2	1
*Transport and storage of water in narrow-necked, covered containers	10	6	1	
*Immunization	0	8		4
*Antenatal care	8	10	3	2
*Complimentary feeding	6	9	6	5
*Use of ORS and medicines according to instructions	5	9		6
*Appropriate care-seeking for danger signs	10	10	1	3

* Selected Behaviors

Phase 3 - Exploring Reasons for the Behaviors

Four of the behaviors that are selected in Phase 2 were investigated more to understand the major barriers to performing the behaviors. The four behaviors that were selected were 1) appropriate care-seeking for danger signs; 2) complementary feeding; 3) feeding sick children; 4) family planning. One page of suggested checklists and methods was developed for each behavior. The larger group split into three teams (the two feeding behaviors were investigated by one group). The team picked out the one page suggestions for each of the selected behaviors. Using this, and based on what had already been found out about the behavior, the checklist and methods were modified. One example is shown below, and the others are attached in the appendix.

Guidelines to understand more about: Breastfeed exclusively for about six months.

What are people doing now?

- Are mothers initiating breastfeeding within a couple hours after birth?
- Are children under 3 months given any supplemental teas, milks, or other liquids?
- Are children under 4-6 months given any supplemental teas, milks, liquids, or solids?
- Are children fed on demand, including night feeding?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

- What do mothers do if they perceive their milk is not enough for the baby?
- What do mothers do if they have to be separated from the infant for more than half a day?

Suggested methods

Beans with key informants (grandmothers, TBAs, mothers of children under 6 months).

- The total pile of beans is all children under 6 months old.
- How many beans are exclusively breastfed?
- Of the beans not exclusively breastfed, what are the main reasons for not exclusively breastfeeding?

Interviews with women exclusively breastfeeding and not exclusively breastfeeding child under 6 months (can be identified from the survey).

Interviews with health care providers, traditional healers.

Common reasons why people do not do these behaviors

Concerns of the mother

- "Child is always hungry" — Mother believes she does not have enough milk for the child
- Women believe that the first milk is harmful.
- "I don't know what to do" — There is no family member or friend who can help the mother when she has a problem with breastfeeding.
- "The weather is very hot" — Concern that the child needs additional fluids on hot days, breastmilk is not sufficient.
- Family members and friends want to help mother, look after child much of the day, mother does not get chance to breastfeed.
- If mother is sick, she should stop breastfeeding or sickness will be transmitted to her child.

Concerns of the father

- Sexual relations not allowed if mother is breastfeeding, so father does not encourage mother to breastfeed.
- Mother spends too much time breastfeeding, neglects others duties, such as agricultural work, care of other children.

Health care providers and traditional healers

- Mother advise not to breastfeed if child has diarrhea.
- Health care providers do not know what to tell mother if she has trouble breastfeeding.

Environmental / economic

- Women do not take their infant to the field, market, or workplace and, hence, cannot breastfeed.
- A mother may not sleep with her infant, making night feeding difficult.

Depending on the behaviors that were selected, different qualitative and participatory procedures were used. These procedures included semi-structured interviews, free listing, matrix ranking, seasonal calendars, and bean counting.

For example, for the behavior on appropriate care-seeking for danger signs, the following checklist was developed for semi-structured interviews:

- Accessibility to health facility—distance, seasonal variations
- Lack of cash
- Ignorance of danger signs
- Mother may need permission from husband or elder to take the child
- Other people (father, grandparents) may disagree with need to take child
- Health staff may treat clients poorly (e.g., scolding)
- May be embarrassed to go to clinic due to poor clothes or malnourished child
- May prefer other providers, such as traditional healers or drug vendors

Using this checklist, several semi-structured interviews were completed. Then, a group of women were asked to draw a seasonal calendar of illness and resources. The calendar drawn by the women is shown below:

Women's Seasonal Calendar - Mutubaya

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
work in fields	00000	00000	00000	00000	000 00	00000	00000	0000	0000	0	0000000 0	00000
amount of food	"There's literally nothing"					00000 0	00000 0	0000	000	00	0	
amount of money						00000	00000 0	00000	0000	00	0	
types of illness		malaria diarrhea chest infection	malaria diarrhea chest infection	malaria diarrhea chest infection		cough	cough	sore eyes	sore eyes	diarrhea sore eyes	diarrhea	
deaths	0	00	00	00	0	0	0	0	0	0	0	0
access to health facilities	----- same all year round -----											

After the seasonal diagram was completed, the women ranked sources of health care for various illnesses. For magic illnesses, they preferred traditional healers, and for *nkombola*, the problem is believed to be with the mother and is treated by a “group of women” (includes several elderly women and the TBA, who perform surgery on the mother’s vagina in order to cure the child’s illness). These interviews were inadequate to understand the local conceptions of these illnesses. The results of the ranking are shown in the table below:

Ranking of Health Care Sources for Different Illnesses (1=first choice of treatment)					
	Health centre	Traditional healer	“Group of women”	CHW	Drug vendor
malaria	2				1
diarrhea	2			1	
measles	1				
magic illnesses		1			
<i>nkombola</i>			1		

The results of the semi-structured interviews and other methods were analyzed by simply listing the reasons why people were doing and not doing the selected behavior. An example of this for appropriate care-seeking behavior is shown below:

EXAMPLE: Reasons for Seeking Appropriate Care	
<u>Reasons for doing the behavior</u>	
■	Recognize danger signs
■	Escorted by family member to clinic
■	Have money or exercise book
<u>Reasons for not doing the behavior</u>	
■	Attacked and raped on the way to clinic
■	No money to buy exercise books
■	Distance is 7 km
■	Scolded by clinic staff
■	Do not recognize danger signs
■	Suspect witchcraft
■	Child’s illness is due to a problem with the mother.

18

Phase 4 - Developing Intervention Strategies and Next Steps

After the teams had explored some of the reasons for the behaviors, they presented this to the larger group and developed possible intervention strategies.

The intervention strategies came from the semi-structured interviews and group discussions to understand the reasons for the behavior. Some of the strategies were suggested by community members and some came from the MOH team. An example of the strategies for measles vaccination is shown in the table below. Note that it relates very closely to the reasons for appropriate care-seeking shown above.

EXAMPLE: Strategies for Appropriate Care-seeking

Strategies - Community

1. Discuss attacks and escort women to clinic
2. Assist in CHW selection
3. Form neighborhood committees

Strategies - Health Center

1. Procure and subsidize exercise books
2. Assist in CHW selection
3. Staff meetings to improve patient interactions
4. Conduct group and individual education

Public meeting and risk map

On the final day of the community assessment, another public meeting was called to present the selected behaviors and the strategies. A detailed action plan showing the responsibilities of the community and the health centre was developed and discussed (attached in appendix).

At the meeting, the community risk maps were also presented. Four indicators were selected, based on two criteria: 1) directly related to actions which will be implemented by the project, and 2) which would most assist in targeting high risk households for specific activities (e.g., campaigns, participation in nutrition groups). Each of the social maps for the two communities showed each household with a child under 2 years old. Next to each house, we drew four boxes which were color coded for four indicators. In this way, everyone in the community could see which households were at risk. The way that the four boxes were coded is shown in the table below:

Feeding a sick child Red=child not fed appropriately Green=child fed appropriately	Measles vaccination Red = child 9–23 months not immunized Green = child 9–23 months fully immunized Yellow = child 0–8 months old
Using a narrow-necked container for water Red=not using narrow-necked container Green=using narrow-necked container	Antenatal visits Red = less than two visits in last pregnancy Green = more than two visits in last pregnancy

RESULTS AND DISCUSSION

Indicators

A total of 21 mothers were interviewed which was all the mothers with children under 2 years of age. The results for each of the indicators is shown in the table below. Note that these indicators are in no way representative of the catchment area of Jerusalem Health Centre, but simply reflect the situation in the villages of Chintiko and Mutubaya.

Indicator	Proportion	Percentage
1. Proportion of infants 0–6 months exclusively breastfed	4/9	44
2. Proportion of children with an under-5 card available	16/22	73
3. Proportion of children 9–23 months of age who have received measles vaccine	7/10	70
4. Proportion of children with an under-5 card whose weight was updated in the previous two months	12/16	75
5. Proportion of mothers of children <2 years of age with an antenatal card available	11/21	52
6. Proportion of mothers of children less than 2 years of age who had at least two TT during the last pregnancy	10/15	67
7. Proportion of mothers of children less than 2 years of age who had at least two antenatal visits during the last pregnancy	10/21	48
8. Proportion of mothers of children under 2 years using a modern method of contraception	0	0
9. Proportion of caretakers who know at least two signs for seeking care when their infant or child is sick	17/21	81
10. Proportion of mothers with children under 2 that own mosquito nets	0	0
11. Proportion of children who slept under a mosquito net during the last seven nights	0	0

Indicator	Proportion	Percentage
12. Proportion of mothers with children under 2 which usually use a narrow-necked covered water container to store water	6/21	28
13. Proportion of households with children under 2 with a well-maintained latrine available	0	0
14. Proportion of mothers with soap available for handwashing	1/21	5
15. Proportion of children with illness treated in the home	11/15	73
16. Proportion of children with a serious illness for whom treatment was sought	8/15	53
17. Proportion of children with watery diarrhea receiving ORS/RHF	6/6	100
18. Proportion of children with watery diarrhea receiving an antibiotic	1/6	17
19. Proportion of children with fever receiving an antimalarial	7/13	54
20. Proportion of children with cough, fast or difficult breathing receiving an antibiotic	1/12	8
21. Proportion of children who had been given medicine in the previous two weeks who had been given medications/treatment correctly	3/9	33
22. Proportion of children who had been sick in the previous two weeks who had received fluids appropriately during the illness	3/15	20
23. Proportion of children who had been sick in the previous two weeks who had received food appropriately during the illness	2/15	13
24. Proportion of children under 2 whose weight was updated in past two months who are failing to thrive	6/12	50

PRIORITIES AND STRATEGIES

Based on the survey and the community priorities, a total of nine different behaviors were selected and are shown in the table below:

Results - Selected Behaviors

- Water quality
 - Weaning practices
 - Feeding of sick children
 - Vitamin A intake
 - Care-seeking practices
 - Appropriate administration of medicines
 - Use of modern family planning methods
 - Antenatal care
 - Vaccination coverage
-

While the behaviors provided a focus for the discussions, the strategies and actions plans that were developed address many cross-cutting issues. For example, the strategy for several of the selected behaviors included the selection and training of community health workers and traditional birth attendants. It should also be noted that health education is only one category of the strategies which were identified and that the strategies include some facility-based changes. Perhaps the most notable is that the clinic staff agreed to negotiate the clinic hours with the community based on the finding that community members are busy in their fields in the mornings (when clinics are open) and freer in the afternoons and evenings. The complete action plan is attached in Appendix F.

REVIEW OF THE PROCESS

Overall, the participatory approach to community assessment and planning for maternal and child health programs was very successful. Both the community and the workshop participants felt a sense of ownership of the process and felt that the information collected was accurate. The fact that the process resulted in a concrete action plan rather than simply a research report was critical to the success of this approach. The action plan enabled everyone, especially the MOH and community teams, to respond to the question "What will you do with all this information you are collecting?"

When written up as a formal report, the community assessment process can look daunting and perhaps overwhelming, especially for people with limited time and resources. However, this experience showed that much of the process is intuitive and, hence, easily internalized. At the

end of the process, the MOH teams completed an evaluation of the activity. The results show that these methods are simple and streamlined enough to be a part of routine MOH work for many people. The complete results are attached in the appendix.

Since this is the first time that this process has been field-tested, we will review the experience in detail to make modifications. We expect to field-test this approach in other countries as well. Some of the changes that we will consider include—

- revision of the household questionnaire
- revision of the one-page guidelines for each behavior so that they are in the form of actual checklists for each behavior
- revision and/or deletion of the summary forms
- development of streamlined participant guidelines which include too much text now
- checklist for reviewing the field experience with the participants

NEXT STEPS

At the end of the workshop, each district identified additional health centers for training in this approach. Four health centres were selected in Chama, four health centres in Lundazi, and five health centres in Chipata were chosen for training and implementation of this approach. A detailed training curriculum based on this workshop was written by Elizabeth Burleigh and is attached in Appendix G. One of the challenges for future trainings will be to balance the need for structure with the need to remain flexible and open to different approaches within the training itself. There is a danger that this could become a “blueprint” approach to community partnership which is contrary to the very principles of partnership.

The Environmental Health Project working in urban areas of Kitwe have expressed interest in modifying and adapting this approach for use in urban areas.

A formative research protocol will be developed to understand the care-seeking practices for children with febrile illness. The purpose of this research will be to develop IEC materials and inform the adaptation of the IMCI algorithm and counseling approaches. It is anticipated that the field work could begin in July.

APPENDIXES

APPENDIX A

**Joint Health Facility-Community Problem-Solving Process
Chipata District, Eastern Province, Zambia**

Appendix A
Joint Health Facility-Community Problem-Solving Process
Chipata District, Eastern Province, Zambia

List of Participants

Name	Organization	Position
Geston Moyo	Chama Hospital	Disease Control Manager/EHT
Charles Kamzimbi	Jerusalem Center	EHT
Charity Nalwamba	Lundazi Hospital	EHT
Magdalene Chipeta	Lundazi Hospital	District Public Health Nurse
Mackson Ngambi	Jerusalem Center	Clinical officer
Elizabeth Burleigh	BASICS/Zambia	Community Mobilisation Advisor
Jonathan Chigawu	Chama Hospital	Senior EHT
Justin Mukupa	CBOH	Community Partnership
Catherine Mulikita	NFNC	Nutritionist
Magdalene Siame	MCH/FP, MOH	CDD coordinator
Bertha Musukwa	Chipata, DHMT	Public health nurse
Michaele Davis	Peace Corps	Health educator
Simate Nyambe	Chipata DHMT	Health inspector
Vera Mwewa	BASICS/Zambia	Program Development Officer

APPENDIX B

COMBINED HOUSEHOLD SURVEY
Zambia Child Health Project/BASICS
January 1997

Appendix B

**COMBINED HOUSEHOLD SURVEY
Zambia Child Health Project/BASICS
January, 1997**

District _____	Name of village/community _____
Date ____/____/____	Interviewer number _____

To be completed with every caretaker of a child under two years old

Complete one column for each child less than two years old

What is the name of the household head? _____

What is the name of the respondent? _____

What is the respondent's relationship to the child? ___Mother ___Aunt Other _____

Is child's mother alive? ___yes ___no

1. Household number		
2. Child's name		
3. Child's number		
4. What is (Name's) date of birth ____/____/____ Record date, or write DK if unknown If known, GO TO Q6. If unknown, GO TO Q5.		
5. How old is (Name)? _____ If less than one month old, record "<1 mo" If 1-23 months, record "____mo"		

[Ignore all ** until you have completed the household.]

286

FEEDING

Child's name			
Child's number			
6. Since this time yesterday, has (Name) been breastfed? <i>Yes or no</i> If YES, GO TO Q7. If NO, GO TO Q8.			
7. Since this time yesterday, did (Name) receive? <i>Prompt for each item and tick if YES</i>			
a. Vitamins, mineral supplements			
b. Plain water			
c. Sweet or flavored water			
d. Fruit juice			
e. Tea			
f. ORS solution			
g. Bottled soft drinks			
h. Infant formula			
i. Tinned, powdered or fresh milk			
j. Solid or semi-solid food			
k. Other fluids (specify) _____			
** Child aged six months or less? <i>Yes or No</i>			Total yes=A=
** If six months or less, is the infant exclusively breastfed? <i>Yes or No</i>			Total yes=B=

IMMUNIZATIONS

8. Do you have an under-5 card for (Name)? a. Yes b. Lost it c. Never had one If YES, GO TO Q9 If NO, GO TO Q10			Total yes =
9. Look at the card and record whether measles vaccination has been received <i>(Yes or No)</i>			

29

Child's name			
Child's number			
** Is the child between 12-23 months of age? Yes or No			Total yes = C =
10. Has the child been weighed in the past two months? <i>Yes or No</i>			Total yes=
11. <i>If the child has a card, look at the under-5 card and record the following information:</i> Has the child's weight been entered on the growth monitoring chart in the last two months? <i>Yes or No</i>			Total yes =

QUESTIONS TO THE MOTHER OR CARETAKER:

12. Do you have an antenatal card? a. Yes b. No c. Lost it If YES, GO TO Q13 If NO, GO TO Q14		XXXXXXXXXX XXXXXXXXXX XXXXXXXXXX	
13. Record the number of TT vaccinations received from the maternal health card: a. One b. Two or more c. None		XXXXXXXXXX XXXXXXXXXX	
14. Are you currently pregnant? <i>Yes or No</i>		XXXXXXXXXX	
** Is the women currently pregnant or does she currently have a child 0-11 months of age? Yes or No		XXXXXXXXXX	Total yes = D =
15. Does the card have space to record antenatal care visits? <i>Yes or No</i> If YES, GO TO Q16 If NO, GO TO Q17		XXXXXXXXXX	
16. Record whether the mother made any antenatal care visits for the previous pregnancy: a. One b. Two or more c. None		XXXXXXXXXX	Total of 2 or more =

Child's name		
Child's number		
17. Are you currently using any method to avoid/postpone getting pregnant? <i>Yes or No</i>		XXXXXXXXXX
18. If Yes, What is the main method you or your partner is using to avoid/postpone pregnancy? <i>Ask about each method and tick if yes</i>		XXXXXXXXXX
a. Tubal ligation		
b. Vasectomy		XXXXXXXXXX
c. Norplant		XXXXXXXXXX
d. Injections		XXXXXXXXXX
e. Pill		XXXXXXXXXX
f. IUD		XXXXXXXXXX
g. Barrier method/diaphragm		XXXXXXXXXX
h. Condom		XXXXXXXXXX
i. Foam/gel		XXXXXXXXXX
j. Exclusive breastfeeding		XXXXXXXXXX
k. Rhythm		XXXXXXXXXX
l. Abstinence		XXXXXXXXXX
m. Other (Specify)		XXXXXXXXXX
** Did the woman answer yes to any method a. through i.? <i>Yes or No</i>		XXXXXXXXXX
19. When should you take a child to a health worker or health facility? <i>Do not prompt. Tick all signs mentioned</i>		
a. Don't know		XXXXXXXXXX
b. Fast or difficult breathing		XXXXXXXXXX
c. Not playing		XXXXXXXXXX
d. Looks sick/getting sicker/very sick		XXXXXXXXXX
e. Fever		XXXXXXXXXX
f. Convulsions		XXXXXXXXXX
g. Lethargic/drowsy		XXXXXXXXXX
h. Not eating or drinking/breastfeeding		XXXXXXXXXX
i. Vomiting		XXXXXXXXXX
j. Other (specify):		XXXXXXXXXX

Child's name			
Child's number			
** Does the caretaker know at least two signs for seeking care? Yes or No		XXXXXXXXXX XXXXXXXXXX	
20. Does your household own a mosquito net? <i>Yes or no</i>		XXXXXXXXXX	
21. If yes, did (Name) sleep under the mosquito net any night in the last seven nights? <i>Yes or no</i>			Total yes =
22. Ask to see the vessel that drinking water is usually stored in Is drinking water stored in a narrow-necked, covered, water container? <i>Yes or No</i>		XXXXXXXXXX XXXXXXXXXX	

23. Ask to see the toilet What kind of toilet facility is usually used by household members? <i>Enter a code</i> a. Flush to sewage system b. Flush to septic tank c. Pour flush latrine d. Covered dry pit latrine e. Uncovered dry pit latrine f. No facilities If No facilities, GO TO Q25		XXXXXXXXXX XXXXXXXXXX XXXXXXXXXX XXXXXXXXXX XXXXXXXXXX XXXXXXXXXX XXXXXXXXXX	
24. Observe the latrine: Is it well maintained? <i>Yes or No</i> [Covered, clean, not full]		XXXXXXXXXX	
25. When do you wash your hands? <i>Do not prompt. Tick all that apply.</i> a. Before cooking		XXXXXXXXXX	
b. Before feeding the child		XXXXXXXXXX	
c. After defecating		XXXXXXXXXX	
d. After cleaning the child's stool		XXXXXXXXXX	
e. Other (Specify)		XXXXXXXXXX	
26. Do you have soap for hand-washing in the house? <i>Yes or No</i>		XXXXXXXXXX	
27. If YES, can you see the soap? <i>Yes or No</i>		XXXXXXXXXX	
28. Is there a place for washing hands? <i>Yes or No</i>		XXXXXXXXXX	
29. Is the soap located at the place where hands are washed? <i>Yes or No</i>		XXXXXXXXXX	
** Is answer to both Q28 and Q29 yes? <i>Yes or No</i>		XXXXXXXXXX	Total yes =G =

CHILD ILLNESS

Child's name			
Child's number			
30. Has (Name) had any of these symptoms or problems in the last two weeks? <i>Prompt for each listed symptom and tick if YES</i>			
a. Blocked or runny nose			
b. Difficult breathing due to blocked nose			
c. Fast breathing due to blocked nose			
d. Fever			Total d=
e. Watery diarrhea			Total e=
f. Bloody diarrhea			Total f=
g. Illness with cough			Total g=
h. Fast breathing due to chest problem			Total h=
i. Difficult breathing due to chest problem			Total i=
j. Fast or difficult breathing, don't know cause			Total j=
k. Measles			Total k=
<p>If there are <u>no</u> ticks in d through k, END INTERVIEW HERE and GO TO Thank respondent on the last page If anything is ticked in d through k, continue interview.</p>			

31. Did you do anything to treat (Name) in the home when they developed the illness or no <i>Yes or no</i> If YES, GO TO Q32 If NO, GO TO Q33			Total yes =
32. How did you treat (Name) in the home? <i>Enter the letter corresponding to the response. Specify if necessary</i>			
a. Antibiotic			
b. Other medicine or drug			
c. Traditional remedy			
d. ORS			
e. Home fluid			
f. Other (Specify)			
33. Did you seek care outside of the home when (Name) developed the illness? <i>Yes or no</i> If YES, GO TO Q34 If NO, GO TO Q35			Total yes =

23

Child's name			
Child's number			
34. Where or from whom did you seek care?			
a. Traditional healer/ Religious leader			
b. Government hospital			
c. Government health center or clinic			
d. Private hospital, health center or clinic			
e. Community-based practitioner associated with the health system (CHW)			
f. Private physician / H.W.			
g. Pharmacy, Drug seller (including store or market)			
h. Relative or friend (outside household)			
i. Other provider (specify)			
35. Was (Name) given an antibiotic, antimalarial or ORS/RHF for this illness?			Total a=
a. Antibiotic			Total b=
b. Anti-malarial			Total c=
c. ORS/RHF			
If NO to Q35 (no antibiotic, antimalarial, ORS/RHF), GO TO Q54			
**Did child receive antibiotic, antimalarial or ORS/RHF for this illness? Yes or No			Total yes= I =

FIRST MEDICINE:		
36. What type of medicine is this? [AB=antibiotic, AM=antimalarial, ORS=ORS/RHF, U=Unknown]		
Record name of medicine (e.g. cotrimoxazole)		
37. Who advised/prescribed this drug? Write the code for the adviser / prescriber in the column.		
[a=Traditional healer /Religious leader; b=Government hospital; c=Government health clinic; d=Private hospital, Private health center or clinic; e=Community-based practitioner associated with the health system f=Private physician; g=Pharmacy, Drug seller; h=Relative or friend; i=self; j=Other provider (specify)]		
38. Is the medicine a tablet (T), syrup (S), or injection (I)? Record T, S, or I		
39. How much of this drug/ORS did you give each time?		
40. How many times a day did you give this drug/ORS?		
41. For how many days did you give this drug/ORS?		

Child's name			
Child's number			
SECOND MEDICINE: 42. What type of medicine is this? [AB=antibiotic, AM=antimalarial, ORS=ORS/RHF, U=Unknown] <i>Record name of medicine (e.g. cotrimoxizole)</i>			
43. Who advised/prescribed this drug? <i>Write the code for the adviser / prescriber in the column.</i> [a=Traditional healer /Religious leader; b=Government hospital; c=Government health clinic; d=Private hospital, Private health center or clinic; e=Community-based practitioner associated with the health system f=Private physician; g=Pharmacy, Drug seller; h=Relative or friend; i=self; j=Other provider (specify)]			
44. Is the medicine a tablet (T), syrup (S), or injection (I)? <i>Record T, S, or I</i>			
45. How much of this drug/ORS did you give each time?			
46. How many times a day did you give this drug/ORS?			
47. For how many days did you give this drug/ORS?			
THIRD MEDICINE: 48. What type of medicine is this? [AB=antibiotic, AM=antimalarial, ORS=ORS/RHF, U=Unknown] <i>Record name of medicine (e.g. cotrimoxizole)</i>			
49. Who advised/prescribed this drug? <i>Write the code for the adviser / prescriber in the column.</i> [a=Traditional healer /Religious leader; b=Government hospital; c=Government health clinic; d=Private hospital, Private health center or clinic; e=Community-based practitioner associated with the health system f=Private physician; g=Pharmacy, Drug seller; h=Relative or friend; i=self; j=Other provider (specify)]			
50. Is the medicine a tablet (T), syrup (S), or injection (I)? <i>Record T, S, or I</i>			
51. How much of this drug/ORS did you give each time?			
52. How many times a day did you give this drug/ORS?			
53. For how many days did you give this drug/ORS?			
** Medication(s) all given correctly Yes or No			Total yes = J =
54. During the illness, did (Name) drink much less (ML), about the same (S) or more total fluids (including breastmilk and formula) (M) than usual? <i>Enter ML, S or M</i>			Total M=
55. During the illness did, (Name) eat much less (ML), about the same (S) or more food than usual (M)? <i>Enter ML, S or M</i>			Total S or M=

Thank the respondent. Ask the caretaker whether they have any questions. Ensure that they know how to correctly give ORS and oral medications and that they know correctly the signs for careseeking with their sick child.

36

APPENDIX C

Household Survey Indicators Worksheet

Appendix C
Household Survey Indicators Worksheet

Village: _____

Total Mothers =

Total children=

Indicator	Numerator	Denominator	Proportion	Percentage
1. Proportion of infants 0-6 months exclusively breast-fed	B=	A=		
2. Proportion of children with an under-5 card available	Q8(yes)=	Total children=		
3. Proportion of children 9-23 months of age who have received measles vaccine	Q9(yes)=	C=		
4. Proportion of children with an under-5 card whose weight was updated in the previous two months	Q11(yes)=	Q8(yes)=		
5. Proportion of mothers of children <2 years of age with an antenatal card available	Q12(yes)=	Total mothers=		
6. Proportion of mothers of children less than two years of age who had at least two TT during the last pregnancy	Q13(b)=	D=		
7. Proportion of mothers of children less than two years of age who had at least two antenatal visits during the last pregnancy	Q16(2 or more)	Total mothers=		
8. Proportion of mothers of children under two years using a modern method of contraception	Q18(a-i)=	Total mothers=		
9. Proportion of caretakers who know at least two signs for seeking care when their infant or child is sick	Q19(2 or more)=	Total mothers=		
10. Proportion of mothers with children under two that own mosquito nets	Q20(yes)=	Total mothers=		
11. Proportion of children who slept under a mosquito net during the last seven nights	Q21(yes)=	Total children=		
12. Proportion of mothers with children under two which usually use a narrow-necked covered water container to store water	Q22(yes)=	Total mothers=		
13. Proportion of households with children under two with a well-maintained latrine available	Q24(yes)=	Total mothers=		

14. Proportion of mothers with soap available for handwashing	G	Total mothers=		
15. Proportion of children with illness treated in the home	Q31(yes)=	Total children with illness=		
16. Proportion of children with a serious illness for whom treatment was sought	Q33(yes)=	Total children with illness=		
17. Proportion of children with watery diarrhea receiving ORS/RHF	35(c)	30(e)		
18. Proportion of children with watery diarrhea receiving an antibiotic	Q35(a)=	Q30(e)=		
19. Proportion of children with fever receiving an antimalarial	Q35(b)=	Q30(d)=		
20. Proportion of children with cough, fast or difficult breathing receiving an antibiotic	Q35(a)=	Fast/difficult breathing=		
21. Proportion of children who had been given medicine in the previous two weeks who had been given medications/treatment correctly	J=	I=		
22. Proportion of children who had been sick in the previous two weeks who had received fluids appropriately during the illness	Q54(M)=	Total children with illness=		
23. Proportion of children who had been sick in the previous two weeks who had received food appropriately during the illness	Q55(S,M)	Total children with illness=		
Proportion of children under two whose weight was updated in past two months who are failing to thrive	Growth curve straight or down	Q11(yes)=		

Q30

Total fever = Total d = _____

A= _____

Total diarrhea = Totals (e+f) = _____

B= _____

Total cough/FB/DB = Totals (g+h+i+j) = _____

C= _____

Total measles = Total k = _____

D= _____

Total children with illness = Totals (d+e+f+g+h+i+j) = _____

G= _____

I= _____

J= _____

APPENDIX D

Breast-feed exclusively for about 6 months

Appendix D

Breast-feed exclusively for about six months

What are people doing now?

Are mothers initiating breast-feeding within a couple hours after birth?

Are children under 3 months given any supplemental teas, milks or other liquids?

Are children under 4-6 months given any supplemental teas, milks, liquids or solids?

Are children fed on demand, including night feeding?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

What do mothers do if they perceive their milk is not enough for the baby?

What do mothers do if they have to be separated from the infant for more than half a day?

Suggested Methods

Beans with Key Informants (grandmothers, TBAs, mothers of children under six months)

The total pile of beans is all children under six months old

How many beans are exclusively breast-fed?

Of the beans not exclusively breast-fed, what are the main reasons for not exclusively breast-feeding?

Interviews with women exclusively breast-feeding and not exclusively breast-feeding child under 6 months (can be identified from the survey) Interviews with health care providers, traditional healers

Common Reasons why people do not do these behaviors

Concerns of the mother

"Child is always hungry" -- Mother believes she does not have enough milk for the child

Women believe that the first milk is harmful.

"I don't know what to do" -- There is no family member or friend who can help the mother when she has a problem with breast-feeding

"The weather is very hot" -- Concern that the child needs additional fluids on hot days, breastmilk is not sufficient

Family members and friends want to help mother, look after child much of the day, mother does not get change to breast-feed

If mother is sick, she should stop breast-feeding or sickness will be transmitted to her child

Concerns of the father

Sexual relations not allowed if mother is breast-feeding, so father does not encourage mother to breast-feed

Mother spends too much time breast-feeding, neglects others duties such as agricultural work, care of other children

Health care providers and traditional healers

Mother advise not to breast-feed if child has diarrhea.

Health care providers do not know what to tell mother if she has trouble breast-feeding

Environmental/ Economic

Women do not take their infant to the field, market, or workplace and hence cannot breast-feed

A mother may not sleep with her infant making night feeding difficult

LB

From 6-24 months, provide appropriate complementary feeding

What are people doing now?

At what age are children given mushy, semi-solid foods? What are the main ingredients (oils, animal products, fruits, vegetables)?

What foods are considered inappropriate for children 6-24 months?

What are the variations in feeding within this age group?

What are the seasonal variations in the types of food given?

How often during the day are children fed (are these "meals" or "snacks"? From a shared pot or plate? By mothers, siblings, neighbors and other relatives?

Is tea given with meals?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Suggested Methods

Seasonal calendar of foods, income, access to markets, mothers' work

Food narrative or 24 hour recall with mothers of young children (amounts of raw ingredients and dilution, type and frequency of feedings)

Village walk to observe gardens and how young children are cared for and fed

Observe hygiene handling of food and feeding of infants

Reasons why some people in other cultures do not do these behaviors

Concerns of the mother

Meat and other animal products are not appropriate for infants, should be reserved for men.

"Children can't digest un-diluted foods"

Mothers don't know how to cook to nutritious food combinations, to retain vitamins, etc.

Cultural norms

Children may have to eat from a common pot with older children, with older children eating faster and more.

Children may wander from house to house with neighbors feeding them inappropriate foods.

Higher status people (men, boys) get the energy dense foods (meats, fats, sweets)

Environmental / Economic

Availability and affordability of different foods by season

Different sources of foods - kitchen gardens, markets, subsistence farming

Take infant for measles vaccination as soon as possible after completing nine months

What are people doing now?

Do mothers know when children should get the measles vaccine?

Is measles a disease that mothers want to prevent?

Is the child taken for vaccinations when sick?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Suggested Methods

Beans with Key Informants:

Total beans are all children under two years

How many beans are vaccinated and not vaccinated?

Of the non-vaccinated, what are the main reasons?

Of the vaccinated, what are the main reasons people go?

Interviews with mothers of children under two years who are not vaccinated

Previous vaccination experience (HW treatment, side effects)

Reasons for not getting child vaccinated

Reasons why some people in other cultures do not do these behaviors

Concerns of the parents

"Every child has to get measles" -- Children who don't get measles when they are young may get a worse case of measles later

"Measles is not a big problem here" -- Parents don't see the point of vaccination if there have not been recent epidemics

Fear of side effects or of injections

Health care system

Vaccinations only provided one day a week

Health facility is too far away

Health workers do not check if child has been immunized when he/she is brought to the clinic for another reason

Health workers do not recommend vaccination if child has any other illness

Health workers scold mother for not bringing card or bringing child late

Environmental / Economic

Vaccinations only provided one day a week

Health facility is too far

4/15

**For pregnant women and women of childbearing age,
seek tetanus toxoid (TT) vaccine at every opportunity**

What are people doing now?

Are women aware of the need for TT?

What are the beliefs about getting injections during pregnancy?

How often do women go for antenatal services?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Suggested Methods

Beans with key informants

Total beans are all the mothers of children under two years old

How many beans received two or more TT vaccinations?

How many beans received one TT vaccine?

Of those who received no TT vaccine, what are the main reasons why?

Reasons why some people in other cultures do not do these behaviors

Concerns of the women

Concern that vaccine may be harmful to unborn child

Fear that vaccine may be a form of birth control

Unaware of importance and benefits of TT vaccination

Health care providers and traditional midwives

When mother brings in sick child, health worker does not check to see if mother has been vaccinated.

Health workers do not actively encourage women to come for prenatal consultations because they are too busy treating acute illnesses.

Traditional midwives do not mention tetanus toxoid vaccination to mothers when they make prenatal visits.

Use latrines consistently

What are people doing now?

Where do men, women and young children defecate?

Are latrines available to all households (within 100 metres)?

Are the latrines kept clean (not full and no visible feces) and covered?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Suggested Methods

Beans with key informants (men, elders)

Total beans is all households in the community.

How many beans have a latrine within 100 metres?

For those with a latrine, how many of the latrines are clean and covered?

For those without a latrine, what are the main reasons why there is no latrine?

Reasons why some people in other cultures do not do these behaviors

Knowledge and skills

People do not know why it is important to use latrines.

People think that having everyone defecate in one place increases the spread of disease.

People do not know how to build latrines.

People do not know how to maintain latrines, stop using them because they become too dirty or have a bad smell.

Children's feces is not considered dirty.

Difficult for children to use the latrine.

Environmental

The yard of the house is very small, no place to put a latrine, or latrine has to be located close to the house.

The soil is hard or rocky, difficult to dig a hole deep enough for a latrine.

During the rainy season the latrine overflows.

Water is scarce and perception that using a latrine requires more water.

Economic

Lack of tools to build a latrine.

Wash hands with soap at appropriate times

What are people doing now?

Is soap available in every household?

When are hands washed? (after defecation, before cooking, before feeding a child)

How are hands dried? On a clean cloth?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Suggested Methods

Observations of food preparation and child feeding

Matrix scoring with beans: List all the times you wash your hands and then score with matrix below

Times to wash hands	How much will washing hands at this time prevent illness?	How often do you wash your hands with just water?	How often do you wash your hands with soap?
Before cooking			
After you defecate			
After you clean your child's defecation			
Before feeding child			
Others to be added by respondent			

Reasons why some people in other cultures do not do these behaviors

Knowledge and skills

People think that washing hands takes a lot of water, do not wash hands because water is scarce.

People think that feces of infants are "clean", do not wash hands after handling infant feces.

People wash hands after preparing food instead of before.

"If hands look clean, why wash them?"

Soap means you have to use more water.

Economic

Lack of money to purchase soap.

Lack of water.

Environmental / Economic

Soap is not available or expensive.

Water is scarce.

Continue feeding and increase fluids during and after illness

What are people doing now?

Are young children breast-fed during illness?

Do mothers try to feed even small amounts to children during illness?

After illness, are children given increased amounts of food and energy-dense foods?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Is there a recognition that children need extra feeding during convalescence?

Suggested Methods

Interviews with mothers of children who are currently sick.

Interviews with various types of health workers about the advice they give.

Interviews with key informants using previously generated list of illnesses:

List of Illnesses	Good foods	Bad foods
Illness 1		
Illness 2 etc.		

Reasons why some people in other cultures do not do these behaviors

Concerns/knowledge of parents

"Increasing fluids will make diarrhea worse.

"The child got sick from drinking this dirty water, and if we give him/her more of it, he/she will get more sick".

"A sick person should not eat heavy/hot/fatty foods or should not drink milk".

"A sick person should only drink clear fluids".

"Child won't eat, he vomits everything".

"After illness, the stomach is weak so light foods should be given".

"Breastmilk caused this illness, so it must be stopped".

Health care providers

Health workers recommend that sick child not be given heavy/hot/fatty foods or milk.

Health workers do not give any advice about feeding the child.

Social Support

Grandmothers may have very strong beliefs about what should and shouldn't be fed to sick children.

Mother's lack of time and confidence in preparing and feeding special foods for child.

Child is perceived to have no appetite.

Health workers or traditional healers may advise with-holding food or breastmilk.

49

Mix and administer ORS or appropriate home-available fluids, correctly

What are people doing now?

Which types of diarrhea is treated with ORS or home fluids?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Suggested Methods

Observe mothers mixing the ORS (you provide the sachet).

Interviews with mothers who did and did not use ORS or home fluids during last diarrhea episode (identified from survey).

Interviews with key informants - ranking medicines for different types of diarrhea using samples of available medicines:

Type of diarrhea (including dehydration, sunken fontanelle)	First choice of drug	Second choice of drug	Third choice of drug
Type 1			
Type 2, etc.			

Common Reasons some people do not do these behaviors

Concerns/knowledge of parents

Do not know how to mix ORS.

Do not know how to administer ORS.

Do not know that home fluids can have same beneficial effects as ORS sachets.

ORS does not stop the diarrhea, so it doesn't work very well.

Do not have the appropriate containers.

Child will not drink it.

No time to keep feeding it to the child.

Belief that antibiotics and/or injections are better.

Health care providers

No ORT corner in the clinic.

No instruction on use of ORT in the clinic.

Prescription of antibiotics and other drugs for simple diarrhea.

Economic and other barriers

Lack of time/money to administer ORS to child.

Administer treatment medications according to instructions (amount and duration)

What are people doing now?

Do people usually give their child a full course of antibiotics?

Where do people usually purchase their medicines?

What advice is given when they purchase the medicines?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Suggested Methods

Interviews with drug sellers and pharmacists

Interviews with mothers of children who were recently sick

Interview mothers and take an inventory of medicines in the home and discuss their use, where obtained, what they do with "left-overs", whether they "stock up" on certain drugs. Ask what drugs are important to keep in the house.

Show key informants a few common drugs and ask what they are for, how often and for how long they should be taken.

Reasons why some people in other cultures do not do these behaviors

Concerns/knowledge of parents

Do not want to use up all the drug, in order to have some left over for next illness episode (Especially if drug supply is unreliable).

Parents stop giving the medicine when the symptoms go away.

Parents get use medicines from previous illness episodes or get it from a neighbor.

Parents "stock up" on certain medicines during certain seasons or on market days.

Drug sellers

Drug sellers sell incomplete doses of drug.

Drug sellers sell expired medication.

Drug sellers do not provide information on how to take the drug.

Drug sellers sell unsafe drug combinations.

Health care providers

Drugs out of stock at the clinic.

Health workers do not provide information on how to take the drug or verify mothers' comprehension of it.

Health workers do not provide information on drug side effects.

Economic and other barriers

Lack of money to purchase full course of treatment.

Some of the medications given free at clinic are given or sold to neighbors and relatives.

5

Seek appropriate care when infant or child is recognized as being sick (i.e. looks unwell, is not eating or drinking, develops lethargy or change in consciousness, vomits everything, develops a high fever, develops fast or difficult breathing)

What are people doing now?

What signs or symptoms make a mother worried and seek care outside the home?

What decides when and where a child is taken for care?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Suggested Methods

Interviews with mothers of children who have recently been sick or died

Type and order of health care providers that were visited

Who made the decisions to seek care? Who was consulted and who disagreed?

What signs, symptoms, or events "triggered" seeking care from a health care provider?

What was the "story" of the illness or death?

Seasonal calendar - types of illness, access to health facilities, time available or amount of work, money availability, child deaths

Matrix scoring with beans of health care providers: List all the places you go for health care or medicines. Then list important characteristics of them and score them with up to 10 beans in each row. Then ask "If you could only have one of these providers, which would you choose and why?"

	Place 1	Place 2	Place 3	Place 4
Expense				
Distance, etc.				

Reasons why some people in other cultures do not do these behaviors

Concerns of Mothers

Mother does not think the symptoms are very serious.

The child will be made stronger by suffering this illness.

Mother cannot decide herself whether to take the child for treatment, she must consult others.

Concerns of other family members

Father and grandmother may blame the mother for the child's illness.

There is no time or person to take the child for treatment.

For certain illnesses, traditional healers or drug vendors are preferred.

Environmental / Economic

Health providers are very far.

There is no money to buy medicines or pay fees.

Use and Maintain Insecticide treated nets, especially for children

What are people doing now?

Are people using any type of mosquito net?

Are the nets used all the time or only during certain seasons?

Who sleeps under the nets?

What size and type of beds are used? How many nets would be needed per household?

What are the reasons for doing the behaviors?

Do people like using mosquito nets?

What are the reasons for not doing the behaviors?

Suggested Methods

Observe to see types of beds, whether a net is hanging over the sleeping area.

Interviews with men and women about the benefits and disadvantages of nets.

Seasonal calendar: types of mosquitoes, income availability, diseases caused by mosquitoes

Reasons why some people in other cultures do not do these behaviors

Concerns of Parents

When nets tear, they are no longer effective.

It is difficult to hang the nets.

Children move around a lot and tear the nets.

Cultural norms

Children sleep with their mothers but the nets are used by the fathers.

In polygamous families, each wife has a separate house requiring a separate net.

Environmental/Economic

Nets are expensive, cannot afford them for everyone.

Nets are only used during seasons when there are lots of mosquitos (which may not be malaria mosquitoes).

APPENDIX E

Workshop Evaluation

Appendix E

Workshop Evaluation

What will I do differently?

- I'd allow people to express themselves, before I decide what to do or say.
- I'll be able to approach the community better in solving health problems.
- I'll be able to plan with the community.
- I'll be able to plan my time well to suit everybody at the workshop and give time for relaxation.
- Myself and counterpart will do a risk map with a few villages we work in so that we and the community can see changes.
- Improved rapport
- Improved interview techniques (Probing, open-ended)
- Develop checklists
- Approach problems from a participatory perspective
- Brief staff members
- Implement methodology in catchment area starting with priorities chosen by villagers

The following table shows how the participants assessed their own skills after the workshop (the numbers in the table are the numbers of participants rating themselves in that category):

This workshop helped me to:	Not at all	Somewhat	Quite a bit	A great deal
Be more aware of how I behave in a community			3	7
Provide opportunities for communities to participate in health planning		3	3	4
Improve skills in developing rapport				10
Understand and focus on a few health behaviors		1	6	3
Improve my interviewing skills (questioning, listening, probing)			5	5
Be confident in facilitating and recording different procedures (mapping, venn etc)			2	8
Develop checklists to explore relevant health topics			6	4
Develop a workplan with communities based on their needs, priorities, and constraints			4	6
Have fun	1	1	6	1

APPENDIX F

**1997 Action Plan
Jerusalem Health Centre - Mutubayu - Chimtiko
Eastern Province, Zambia**

Behavioral Objective	Activities	JHC Responsibility	Community Responsibility
1. Improve communitiy organization	<ul style="list-style-type: none"> a. Select a CHW(s) and TBA(s) b. Train and equip CHW and TBA 	<ul style="list-style-type: none"> a. Assist in choosing and training of CHW(s) and TBA(s). b. Train CHW(s) and TBA(s) c. Conduct refresher courses for CHW(s) and TBA(s) d. Equip the CHW(s) and TBA(s) with appropriate equipment and materials e. Work with the community to form the Neighborhood Committee 	<ul style="list-style-type: none"> a. Participate in choosing CHW(s) and TBA(s) b. Participate in Neighborhood Committee
2. Improve water quality	<ul style="list-style-type: none"> a. Construct one protected water source b. Chlorinate two water sources c. Improve protection of two water sources d. Promote storage of drinking water through individual and group education 	<ul style="list-style-type: none"> a. Form village WASHE committee b. Train the CHW to chlorinate the water c. Solicit funds material and technical support d. Provide chlorine e. Coordinate with NGOs, ERZ and donor organizations to construct the water source 	<ul style="list-style-type: none"> a. Provide local materials e.g. stores b. Provide labor c. Participate actively in the WASHE committee

27

Behavioral Objective	Activities	JHC Responsibility	Community Responsibility
<p>3. Improve weaning practices (complimentary foods)</p>	<p>a. Assist the community to provide legumes, e.g. cowpeas, groundnuts and soya</p> <p>b. Help to form a nutrition club</p> <p>c. Provide group health education and individual counseling on breast feeding and weaning practices</p>	<p>a. Contact Ministry of Agriculture Musekela Research Center</p> <p>b. Determine source of legume seeds and methodology of revolving seed fund</p> <p>c. Contact and coordinate with Chipata Nutrition group and community development worker</p>	<p>a. Cultivate the legumes</p> <p>b. Form and actively participate in the nutrition club</p> <p>c. CHW and TBA to counsel mothers of malnourished children</p> <p>d. Growth monitoring of children in the village by the CHW and nutrition club</p>
<p>4. Improve feeding of sick children, including vitamin A intake</p>	<p>a. Conduct group health education on importance of encouraging sick children to eat</p> <p>b. Visit households with sick children to advise on feeding</p> <p>c. Administer vitamin A capsules to children under 6 years</p>	<p>a. Provide CHWs with health education materials</p> <p>b. Provide vitamin A capsules</p>	<p>a. Caretakers to feed their sick children frequent meals in small amounts</p> <p>b. Take children to the health facility</p>

Behavioral Objective	Activities	JHC Responsibility	Community Responsibility
5. Improve care-seeking behavior	<ul style="list-style-type: none"> a. Discuss issue of harrassment on the way to the HC b. Select and train a CHW c. Procure and subsidize exercise books d. Improve staff patient interactions e. Negotiate clinic hours f. Form Neighborhood committee g. Improve recognition of danger signs h. Explore reasons for preference of drug vendors 	<ul style="list-style-type: none"> a. Facilitate discussion of harrassment b. Assist in CHW selection c. Train CHW and supervise d. Procure exercise books e. Decide price of books f. Conduct monthly staff meetings to review staff patient interactions g. Facilitate negotiation of clinic hours h. Facilitate formation of Neighborhood Committees i. Continue group education and intensify individual counseling j. Develop cheklist and conduct interviews with drug vendors 	<ul style="list-style-type: none"> a. Select a CHW b. Form a Neighborhood Committee c. Participate in group discussions on <ul style="list-style-type: none"> - harrassment - danger signs - clinic hours - drug vendors - staff attitudes d. Participate in individual counseling on danger signs

69

8

Behavioral Objective	Activities	JHC Responsibility	Community Responsibility
<p>6. Improve appropriate preparation and administration of ORS, antibiotics and antimalarials</p>	<p>a. Train TBAs, CHWs, CBDs in appropriate administration of ORS, antibiotics, antimalarials</p> <p>b. Train facility-base health workers to counsel mothers on appropriate administration of ORS, antibiotics and antimalarials</p> <p>c. TBA, CHW, CBDs conduct individual and group education on ORS/drug administration.</p>	<p>A. Conduct and provide training to TBAs, CHWs, CBDs</p> <p>b. Request training on counseling skills from DHMT</p> <p>c. Supervision of TBAs, CHWs, CBDs group and individual education sessions</p>	<p>a. Select TBAs, CHWs, CBDs for training</p> <p>b. Participate in individual and group education sessions</p>

Behavioral Objective	Activities	JHC Responsibility	Community Responsibility
<p>7. Improve use of modern family planning methods</p>	<p>a. Inventory of existing NGOs carrying out FP activities</p> <p>b. Training of HC staff in FP and counseling skills</p> <p>c. Identify and train TBAs, CHWs, CBDs who will deliver FP services</p> <p>d. Provide group, individual and couples health education and counseling</p> <p>e. Provide modern FP methods</p> <p>f. Develop IEC materials with community and distribute</p>	<p>a. Contact NGO or CBD and brief them on planned activities</p> <p>b. Mobilize training materials, resource persons, funds and venue for training</p> <p>c. Inform the Neighborhood Committee to identify the CBAs to be trained</p> <p>d. Conduct group, individual and couples health education and counseling</p> <p>e. Make available modern FP methods at the HC</p> <p>f. Source for funds for development and distribution of IEC materials</p> <p>g. Conduct monthly supervision of CBAs</p>	<p>a. Participate in planning and implementation of activities</p> <p>b. Select CBAs through the Neighborhood Committee</p> <p>c. Monitor utilization of services</p> <p>d. Couples should be willing to attend FP services</p> <p>d. Couples should be willing to attend FP sessions</p> <p>e. Organize drama groups for awareness campaigns</p> <p>f. Assist in the dissemination of information to the community</p> <p>g. Report monthly (FP activities)</p> <p>h. Participate and distribute IEC materials</p> <p>i. Collect and distribute modern FP</p>

12

Behavioral Objective	Activities	JHC Responsibility	Community Responsibility
<p>8. Improve antenatal coverage</p>	<p>a. Identify and train TBAs</p> <p>b. Conduct health education on importance of ANC</p> <p>c. Conduct ANC sessions in the community</p> <p>d. Facilitate communication between HCs and community</p> <p>e. Develop IEC materials on ANC</p>	<p>a. Inform NHC to identify TBAs to be trained</p> <p>b. Source for funds for materials, resource persons and venue for training</p> <p>c. Conduct ANC outreach activities</p> <p>d. Conduct group and individual health education and counseling</p> <p>e. Monthly follow up and supervision</p> <p>f. Meeting with NHC to discuss effective communication between HC and community</p> <p>g. Make available IEC materials on ANC</p>	<p>a. Select TBAs through NHC</p> <p>b. Mothers should attend ANC sessions</p> <p>c. TBAs to conduct ANC session in the community</p> <p>d. Community should be willing to solve community problems</p> <p>e. Community to participate in the development and distribution of IEC materials on ANC</p> <p>f. Report monthly</p>
<p>9. Complete vaccination coverage in children 9-24 months</p>	<p>a. Visit households with children 9-24 months and check vaccination status</p> <p>b. Vaccination of children in households</p> <p>c. Detect newborns and promote vaccination</p>	<p>a. Community assembly to discuss</p> <p>b. Household visits with CHW</p> <p>c. Vaccination of children 9-24 months</p> <p>d. Modify risk map in JHC and in community</p> <p>e. Community assembly to present results</p>	<p>a. Participate in assembly</p> <p>b. CHW and NHC members participate in vaccination</p> <p>c. CHW and NHC members present results to community</p> <p>d. Caretakers of children 9-24 months agree to immunization</p>

APPENDIX G
Detailed Training Curriculum

PARTICIPATORY APPRAISAL AND PLANNING WORKSHOP
ZAMBIA CHILD HEALTH PROJECT
1997

[Written by Elizabeth Burleigh based on workshop conducted by Karabi Bhattacharyya
in Chipata, Eastern Province]

DAY 1

I. GREETINGS AND INTRODUCTION TO THE WORKSHOP

- a. Have each person present him or herself to the group

2. STRING EXERCISE (NETWORK OR COBWEB)

a. Ask participants to form a circle. One person is given a ball of string. That person introduces him or herself and then gives a bad or good experience with community participation and then holds the end of the string and throws the ball to another person and so on until everyone in the circle is connected and a network of string has been formed.

b. Before they let go of the string, ask them what they have formed (a network) and what it means for community participation (the inter-connectedness of each of the partners and their support and interest in working with community).

3. EYE AND EAR

a. Explain the role of an Eye (to observe and report) and an Ear (to listen to participants observations and report). Each day the Eye and Ear will change.

b. Ask for volunteers as the Eye and Ear for the day

4. BRIEF OVERVIEW OF ZCHP SUPPORT TO THE HEALTH REFORM

a. Explain that the Zambia Child Health (ZCH) project is designed to support the health reform taking place in Zambia and to assist in achieving its goal of improving the health status of Zambians(including children) by bringing cost-effective and affordable promotive, preventive and curative health services as close to the community as possible.

b. Five major outputs for ZCHP are:

- Improve health center community partnership for child survival.
- Training to improve quality of services provided at the health center level.

- Strengthening MOH technical capacity in health systems development at central, provincial and district levels.
 - Strengthening the HMIS at community, health center and district level.
 - Strengthening the public - private sector partnerships for child health.
- c. Under objective no. 1, there are two approaches to community partnerships:
- Support to District-health center-community partnerships, like the one we will form in these two weeks, and
 - Support to NGO-District partnerships
- d. Present the example of Chipata District-Jerusalem Health Center-Mutubayu/Chimtiko Villages as an example

5. STEPS IN THE PROBLEM SOLVING PROCESS

a. Explain the steps of a joint health facility-community problem solving process. (Explain underlined words and each step below).

- Build partnerships between the District-Health Centers-Communities
- Identify priority behaviors in prevention in which the partnership needs to work
- Explore the reasons for those behaviors and develop intervention strategies
- Develop a joint Partnership Workplan for 1997-1998

b. Overview of schedule and its relation to these steps

- Days 1-3: Build the first part of the partnership (District-HC) and learn PRA methodologies
- Days 4-6: Work with the community to identify priority behaviors in prevention
- Day 7: rest day
- Day 8-9: Work with the community to explore reasons for those behaviors
- Day 10: Develop intervention strategies and a draft joint Workplan and discuss with the community
- Day 11: Revise workplan as necessary and do a Risk Map, then have a final meeting with the community to thank them for their participation
- Day 12: Workshop evaluation, and agreement on Next Steps by each District (am only)

6. EXERCISE I: WHY DO CHILDREN DIE?

- a. Ask the participants to list the major "causes" of child death in Zambia (they will list medical causes such as diarrhea, ARI or malaria).
- b. Tell a story of a child's death (write it on a flipchart): (*insert story here)

65

- c. Break the group into working groups and have them discuss the story and list the reasons for the child's death.
- d. Back in the wider group, each working group then presents it's conclusions.
- e. Ask them what the different kinds of "causes" of death or illness are (social and cultural as well as medical), and tell them that it is often easy for us to forget that all these factors play an important role in child death or well-being. If we do not know what is really going on and what the factors are in illness and death, we will not be able to prevent them. So how do we find out?.

7. EXERCISE 2: EXPLORING PARTICIPATION

- a. Ask participants to silently brainstorm about the question "**What is Participation?**"
- b. Discuss with the group. Each participant gives an idea of definition and the facilitator writes main elements on flip charts.
- c. Divide the group into working groups. In groups the participants should answer the following questions:
 - How can participation help me in my work?
 - How can participation improve the health of children?
 - what are the main obstacles or difficulties to participation?
- d. Back in the main group, each working group explains its conclusions the the group as a whole.
- e. The facilitator then summarises key points from the working groups.
- f. The facilitator then presents the various **levels of community participation** on a flipchart:
 - Passive use of existing services (lowest level).
 - Financial or material contribution (middle level)
 - Full participation in decision-making (planning and implementation) (highest level)
- g. Group discussion about these levels, giving examples from their experiences.

8. EXERCISE 3: INSIDER AND OUTSIDER KNOWLEDGE

- a. Present the concept of "Johari's Window" on a flipchart:

Things we know and what they do not know	What they know and what we do not know
What we know and they do not	What we do not know and they do not know

- b. Divide into working groups and have each group think of examples
- c. Each group presents its examples to the larger group and discusses
- d. The facilitator explains that it is important that we learn to LISTEN and ASK QUESTIONS rather than lecture to the community if we hope to understand their lives and help them to prevent illness and death. Too often we get in the habit of lecturing, and the community gets in the habit of listening passively.
- e. Knotty problem: (explain here*)

9. EXERCISE 4: KEY BEHAVIOURS NECESSARY TO ENHANCE PARTICIPATION

- a. Present the key behaviors necessary to enhance participation on a flipchart and discuss with the group as a whole asking them what each one means:
- Critical self-awareness
 - Commitment to the poor and vulnerable
 - Respect for the opinions and beliefs of others
 - "Handing over the stick"
 - Flexibility
 - Not lecturing, being good listener
 - Embracing error
 - "They can do it" attitude, empowering others rather than thinking we always have to do it for them

10. EXERCISE 5: CONFLICT AND COOPERATION

- a. Hand out pieces of paper to each person and tell them not to let anyone else see. Each piece of paper will have ONE of the following instructions:
 - Put chairs near the door.
 - Put chairs by the wall.
 - Put chairs in circle.
- b. Instruct the group to do what is instructed on their pieces of paper without talking to anyone else. Wait eight minutes.
- c. Ask participants:
 - How they feel etc. depending on how they behaved
 - What was the outcome of the exercise?
 - How best could they have worked out their differences?
 - What has this to do with working in a community?

11. EXERCISE 6: BEHAVIOR CHANGE AND THE KEY BEHAVIOURS RELATED TO PREVENTION

- a. The facilitator presents the list of Key Behaviors which are related to prevention. A community-level activity in prevention should focus on changing key behaviors which are the cause of priority illnesses such as diarrheal disease and ARI, malaria and AIDS (see attachment).
- b. Participants to break into working groups. Each group is assigned a behaviour or two to go review. Groups should discuss its importance and situation in Zambia.
- c. Back in the larger group, each of the working groups presents its conclusions and discusses them with the group.

12. EXERCISE 7: SOCIAL MAPPING

- a. Ask participants to each draw maps of their neighbourhood on paper including the following information:
 - directions (north, south, west, east).
 - location of their house
 - any other information they would like to include
- b. Ask participants:
 - Did your map fit on the page?
 - what did you do when you came to the edge of the paper?.

- Did you make mistakes?.
 - What other information did you decide to include on your map?
 - Why did you think these other things were important?
- c. Tell participants that, in the community, they will work with community members to make a map of the community on the ground using symbols such as rocks and leaves. This technique is called Social Mapping.
 - d. Show an overhead example of a Social Map and pass around photos from Chipata (or show on overhead if available)(see attachment).
 - e. Break into two groups, with a facilitator and recorder for each group. Review the Social Map checklist with them (see attachment):
 - f. Each group makes a map of an "imaginary village" using beans and other natural /local materials. The facilitator guides (not controls) the group to make sure all the elements in the checklist are included, while the recorder copies map onto paper.
 - g. Once completed, the groups look at each other's maps while owners explain.

12. END OF THE DAY REPORT FROM THE EYE AND THE EAR

- a. Ask the Eye and the Ear to report their observations to the group.

DAY 2

I. SELECTION OF THE EYE AND THE EAR FOR DAY TWO

2. EXERCISE 1: FOUR PHASES OF THE PROBLEM SOLVING PROCESS

- a. The facilitator presents the four phases of problem solving and discusses each with the group:
 - Building partnerships - making a map
 - Collecting information (household survey) plus selecting behaviors with the community
 - In-depth exploration of reasons for behaviours (use PRA - ethnog)
 - Develop intervention strategies

3. EXERCISE 2: ROLES AND USE OF A FIELD NOTEBOOK

- a. The facilitator explains the roles of group facilitator, observer, and recorder.
- b. Review the use of the Field Notebook, telling participants they should record the following in preparation for the work with the community and during the field work:
 - The name of village
 - Date
 - Name of recorder
 - Name of facilitator
 - Name of observer
 - Type of exercise conducted
 - Any relevant information about participants such as gender
 - Record map checklist for construction of the Social Map
 - Copy the Social Map
 - Record interviews

4. EXERCISE 3: INTERVIEWING TECHNIQUES

- a. The facilitator presents the various types of interviews and techniques and gives examples to the group:
 - Semi-structured interviews
 - In-depth interviews
 - Establishing rapport
 - Open ended questions
 - Probing
 - Listening

5. EXERCISE 4: ASKING QUESTIONS

- a. The facilitator explains the different types of questions giving examples for each:
 - Closed-ended (can only be answered yes or no)
 - Judgemental (question where one has already formed opinion, e.g. why don't you use toilets?)
 - Leading questions (question that gives an answer e.g. don't you think fast breathing is a danger sign? or Shouldn't you take your child to the clinic when he/she has fast breathing?)

- Ambiguous (Vague questions, unclear e.g. how do you get your medicine?)
 - Open ended (Cannot be answered with just a yes/no)
- b. The facilitator then explains the Six Helpers: who, what, when, where, why, how, to be used in formulating open-ended questions.
 - c. Practice with sample questions in groups, asking them to categorize the following examples and then rephrase each of them into open-ended questions:
 - Is it difficult to get to the clinic during the rainy season?
 - How do you find the traditional healer?
 - Would you not prefer the health centre to the drug vendor?
 - Is it important to feed your child meat?
 - Should you not get your child vaccinated?
 - d. In the larger group, discuss how each of these questions was categorized and how they could have been said as an open-ended question.

5. EXERCISE 6: PRACTICE INTERVIEWING

- a. Two trained facilitators to do a role play of an interview for 3–5 minutes to demonstrate proper interviewing techniques. After this is done, the group should be free to comment and correct any leading or incorrect types of questions.
- b. Divide the group into pairs and have each pair select one of the Key Behaviors. Each pair should then practice asking questions, trying not to use incorrect techniques. Each person should have the opportunity to be an interviewer as well as a respondent. The respondent should pretend not to be practicing the behavior in question. The interviewer should try to find out why and pose possible solutions. Practice probing without leading.
- c. Back in the wider group, discuss the experience.

6. EXERCISE 7: VENN DIAGRAM / CHINGELELE / INSTITUTIONAL DIAGRAM.

- a. The facilitator defines of the Venn Diagram technique as follows: A diagrammatic representation of the different types of institutions, organisations, individuals and services in a community.

71

b. The facilitator then defines the following terms, with participation from the group:

- Institution
- Organization
- Services
- Individual

Examples of each might be the following:

Institution

School
Health center
Church
Agricultural department

Organisation

NGO
Women's group
NHC
WASHE

Individual

Chief
Headman
Pastor
Traditional healer
TBA

Services

Under five clinic
Health
Education
Counseling etc

- c. The facilitator then shows by example what a Venn Diagram looks like: A big circle representing the community with different shapes or symbols to represent institutions, organisations, services, individuals. He/she illustrates how to place the various shapes and symbols as well as the various factors which should be taken into consideration e.g. Importance (size of symbol or colour), distance (position), degree of coordination (intersecting, partial or complete).
- d. Use an overhead example of a community making a Venn Diagram (Chipata).
- e. Break into working groups and practice making a Venn Diagram of a fictitious community using coloured cards of different shapes and sizes. Use the checklist from the participants guide, and practice being a facilitator, recorder and observer.
- f. Each group then shows their Venn Diagram to the larger group and explains what the symbols mean.

7. FRUIT SALAD ENERGIZER

- a. Get the group in a circle and have each person be one of three types of fruits:

(*how does this go???)

8. EXERCISE 7: CONSTRUCTING A SEASONAL CALENDAR

- a. Facilitator describes a Seasonal Calendar: A calendar made up of natural materials on the ground that is used to illustrate seasonal variations over the months of the year.
- b. Show an overhead example of a Seasonal Calendar (Chipata)
- c. Steps to constructing a Seasonal Calendar:
 - First get the local break down of seasons, months, in a year.
 - Then ask the community members to rate the occurrence of the subject over the year. For example, this might be the occurrence of particular diseases, particular crops, or labour, food availability, yearly activities, etc.
- d. Use Seasonal Calendars to demonstrate the relationship between different factors such as food availability and disease, and to avoid seasonal biases (not getting a clear idea of the community situation because you are only there at one time of the year).
- e. Draw on a flipchart examples of Seasonal Calendars as follows:

	J	F	M	A	M	J	J	A	S	O	N	D
Work in	
								field	.	.	.	.
	.	.	.									
.....								Diarrhoea	.....		
								Malaria	.....		.....
....				Food	.	.	..	....
								availability				

73

- f. Explain that there are often differences in Seasonal Calendars made by different subgroups within the community since each has different interests and priorities. Therefore, it is often a good idea to do several Calendars, dividing the community into sub-groups:
- gender men/women
 - age group
 - social class/group
- g. Break into working groups and practice making a Seasonal Calendar using natural materials which is designed to answer the following question and obtain the following information:
- Question: When do people sick care?
 - Checklist: Access to health facilities
Time available/amount
Amount of work
Money available
Food available
Child deaths
- h. Once the Calendars are completed, each group explains their calendar to the rest of the group and answers questions.

9. EXERCISE 8: THE TECHNIQUE OF FREE LISTING

- a. The facilitator explains that in this technique the community is asked to freely list all of the items they consider to be important which fall into a particular category of interest to the investigator. For example, if the investigator is interested in childhood illnesses or fruits, the lists might look like this:

<u>Child illnesses</u>	<u>Fruits</u>
Malaria	Orange
Diarrhoea	Banana
Pneumonia	Mango
Malnutrition	Guava
Measles	Pawpaw

10. EXERCISE 9: MATRIX SCORING

- a. **Scoring by Values:** The Facilitator explains that a Free List may then be scored by the community to determine the relative value of each item on the list. This value might relate to its severity, commonness, or any other

value. Community members are asked to mark each item with a stick or stone or other natural material, with 10 being the highest score, and 0 being the lowest. For example:

Score (10 is the highest score possible)

CHILD ILLNESS	COMMON	SEVERE
Malaria	10	10
Diarrhoea	10	9
Pneumonia	10	9
Malnutrition	7	6
Measles	4	10
Whooping cough	1	8
Bilharzia	1	1
Polio	1, 1.5	1
Worms	8	1

- b. Explain to the group that once the items are Scored in this way, the Scores may be Ranked to determine which illness is most likely to cause many child deaths. For example, an illness such as Malaria which is common and severe is more likely to cause many deaths that an illness which is also severe such as Measles but much less common.
- c. **Scoring by Criteria:** Items on a Free List may also be scored by specific criteria. For example:

	Traditional healer	CHW	Relative or neighbour	Health centre
Time availability	20	20	20	10
Distance	20	15	20	5
Expense				
Culturally acceptable				
Knowledge/skill				
Drug availability				
Time spent				

75

- d. Explain that this kind of Scoring may be used to find out how people compare things.
- e. Form working groups to practice constructing a Free List and scoring. Groups may use any topic they want to use, but scoring should be done with natural materials.
- f. Once the groups have completed their matrixs they explain them to the rest of the participants.

11. EXERCISE 10: SEQUENCE RANKING

- a. The facilitator explains to the group that lists may also be Ranked in sequence, for example, if one wants to determine which provider is seen first, second, third, etc.for which disease, the sequence ranking might be as follows:

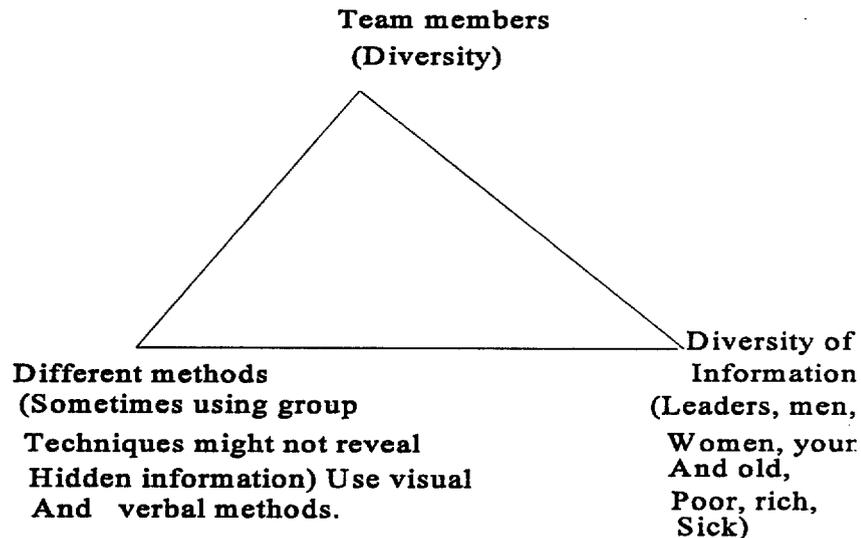
Diseases	Traditional healer	CHW	Neighbour	Health centre
Diarrhoea	1	2	2	3
Pneumonia	1		2	
Malaria	4	3	2	1

12. EXERCISE 11: JUDGING THE QUALITY OF INFORMATION

- a. The facilitator presents and discussed the various Types of Information:
 - Fact: Generally agreed truth.
 - Opinion: One person's or group's view/s.
 - Rumor: Not established truth, unsubstantiated

From the "grape vine" i.e. from an unknown source.

- b. Break into working groups and hand out pieces of paper with a story> Have participants read the story, decide whether each of the statements made is fact, opinion or rumor.
- c. In the larger group, discuss each of the statements and reach consensus on the type.
- d. Explain Triangulation, a technique used to verifying information and establish truth. Triangulation is verifying statements by talking to other people and looking at the situation from different angles, having diverse people on the Team.



12. EXERCISE 11: PRACTICE USING THE SURVEY INSTRUMENT

- a. Break into pairs and practice being the respondent and the interviewer with the actual household survey instrument. The facilitator should observe these practice interviews to detect any problems and provide assistance, without being too directive. Time the practice pairs to determine the average time each interview will take. Practice should be conducted in the local language if appropriate.

(*review the instrument first? Translate parts?)

13. EXERCISE 12: DEVELOPING TEAM CONTRACTS

- a. Break into working groups and review a list of common Team problems and discuss how each should be handled if it occurs (see handout*).
- b. Back in the larger group, discuss each problem and how the groups thought it should be handled. Try to reach consensus on behavior including any signals that team members will use to remind each other to "hand over the stick".

14. REVIEW OF GOALS AND SCHEDULE FOR THE FIRST FIELD DAY (DAY 4)

- a. Work with the full group to develop a checklist for the agenda at the first community public meeting. Determine who in the Team will be responsible for which part of the agenda:

- Introduction of team.
- Purpose of activity - talk about Chipata.
- Role of the community volunteer.
- Explain schedule

- Explain that we will develop an Action Plan to be implemented by health centre, community over the year.
- Explain that we want to talk to as many people as possible.
- Open the meeting up for questions
- Divide the community into village groups for mapping

- b. Venn Diagram and Social Mapping: Form groups responsible for Social Mapping and Venn Diagrams. Make sure they bring their field notebooks with checklists, as well as materials needed for maps and diagrams. Select facilitators, observers and recorders for each group.

15. END OF THE DAY REPORT FROM THE EYE AND THE EAR

- a. Ask the Eye and the Ear to report their observations to the group.
- b. Select an Eye and Ear for the next day..

DAY 4

Before leaving for the field, review the tasks for this Field Day with the Team.

ITEMS TO CARRY TO THE FIELD: markers, field notebooks, beans, maize (seeds), cards in different shapes, sizes and colours, white board for Risk Maps, checklists, lunch, water, camera to document the experience.

- 1. COMMUNITY ASSEMBLY**
- 2. SOCIAL MAPPING**
- 3. VENN DIAGRAMS**

Day 5

Before leaving for the field:

- Make sure the Eye and Ear report.
- Give the Team time to discuss the experience from the day before. Stick Maps and Venns on the walls and have each group explain their diagram or map to the group as a whole. Discuss findings and identify anything that is unclear and needs to be clarified in the community that day.
- Number all the households with children under two on the Maps.
- Number the survey instruments to correspond to the household numbers on the Maps.
- Select an Eye and Ear for the day.
- Review the day's tasks with the Team.

ITEMS TO CARRY TO THE FIELD: markers to correct the Maps as necessary, field notebooks, survey instruments, pencils and erasers, lunch, water, camera to document the experience.

- 1. HOUSEHOLD SURVEY DATA COLLECTION**
- 2. CORRECT THE MAPS IF NECESSARY**
- 3. REVIEW SURVEYS DONE FOR COMPLETENESS BEFORE LEAVING THE COMMUNITY**



DAY 6

1. EXERCISE 1: HAND TABULATION OF THE HOUSEHOLD SURVEYS

- a. Divide into working groups and give each group an equal number of completed survey instruments.
- b. Have each group use the summary sheet to add up the totals for their instruments.
- c. Use the summary sheets to tabulate indicators, putting the results on a flipchart.
- d. Review overall results indicator by indicator with the team.

DAY 7

(Rest day)

DAY 8

1. EXERCISE 1: SELECTION OF PRIORITY BEHAVIOURS

- a. Divide into working groups and ask each group to review the results of the survey, and select the ten most important behaviors which need attention for that community.
- b. Back in the larger group, each working group presents their results and the wider group is assisted to reach consensus on the final list of 10 priority behaviors.
- c. The facilitator explains to the group that it should now pick several of those behaviors (one for each working group) that it would be important to know more about. In the afternoon the group will go to the community and conduct rapid ethnographic data collection on these behaviors. The group identifies at least three of these behaviors.
- d. Divide into working groups, each of which is assigned one of these behaviors. In the small groups, the members discuss the techniques they will use in the community to elicit in-depth information regarding that behavior. Each group develops a checklist of questions which they will need to ask. Take into account: Why they are not doing the behaviors (barriers), and what they suggest could be done. Determine who in the group will do

what. Assign roles (recorder, facilitator). Remember to use open-ended questions.

Before leaving for the field:

- Make sure the Eye and Ear report.
- Select an Eye and Ear for the day.

ITEMS TO CARRY TO THE FIELD: field notebooks, pencils and erasers, lunch, water, camera to document the experience.

1. IN-DEPTH DATA COLLECTION REGARDING SPECIFIC PRIORITY BEHAVIORS

DAY 9

1. EXERCISE 1: RESULTS OF RAPID ETHNOGRAPHIC DATA COLLECTION ON SPECIFIC BEHAVIORS

- a. Divide the group into the working groups which collected specific ethnographic data the day before. Each group prepares a flipchart presentation on the results of their research which tells us:
 - 1) Which behavior they were investigating
 - 2) The techniques they used for data collection and the gender group interviewed
 - 3) The results of their research
 - 4) What people are doing now
 - 5) What are the reasons for doing the behaviour?
 - 6) What are their reasons for not doing the behaviour (barriers)?
- b. Each group writes on the flipcharts and presents their findings to the larger group for discussion.

2. EXERCISE 2: IDENTIFICATION OF BEHAVIORAL OBJECTIVES FOR THE WORKPLAN

- a. Divide back into the same working groups and ask the groups to develop "Behavioral Objectives" for each of the ten priority behaviors. These Behavioral Objectives will be used the following day as the basis for developing a Work Plan.

81

DAY 10

1. EXERCISE 1: DEVELOPING A WORK PLAN

- a. Divide into working groups, each of which is responsible for a set of Behavioral Objectives. Add an Objective related to Community Organization, if necessary (to include formation of NHCs, and training of CHWs, etc.).
- b. Each working group is asked to develop a Work Plan for each of the Behavioral Objectives, in the following matrix. Remind groups to keep in mind all of the community information regarding these behaviors. Try to develop a Plan for each Behavior which is realistic in the community context, and within the timeframe of 12 months:

Behavioural objective	Strategies activities	Health centre responsibility	Community responsibility

- c. In plenary discuss each working group's matrix for each Behavioral Objective. Participants select most important points to discuss with the community.

Before leaving for the field:

- Make sure the Eye and Ear report.
- Select an Eye and Ear for the day.

ITEMS TO CARRY TO THE FIELD: field notebooks, pencils and erasers, lunch, water, camera to document the experience.

1. PRESENT THE JOINT WORK PLAN TO THE COMMUNITY AND DISCUSS

This may be done with the community or representatives (NHCs, CHW, TBAs, Headmen) in one group or in two small groups discussing different topics. (This to be decided depending on the convenience and results required.)

Make sure the community understands it's role in the Work Plan and has an opportunity to discuss.

DAY 11

1. EXERCISE 1: RISK MAPPING

- a. The facilitator assists the larger group to select key indicators from the household survey to put on community maps based on:
- which indicators are directly related to the actions/activities which will be implemented by the project;
 - which indicators would assist in targeting specific high risk households for specific activities such as participation in campaign, groups etc.
- b. Develop the Key i.e. for each Map: One indicator corresponds to one box.

Red - Very bad
Yellow - Partially (incomplete)
Green - Good

- c. Once four indicators have been selected, each person in the group is given a set of survey instruments and he/she places the information on the Map in the box that corresponds to that household (green=).

Before leaving for the field:

- Make sure the Eye and Ear report.
- Select an Eye and Ear for the day.

ITEMS TO CARRY TO THE FIELD: field notebooks, pencils and erasers, lunch, water, camera to document the experience.

1. FINAL PUBLIC MEETING

- Present the findings on the risk map (without mentioning names).
- Present the immediate next steps.
- Find out their feelings on our attitude (verbal evaluation by the community).

13

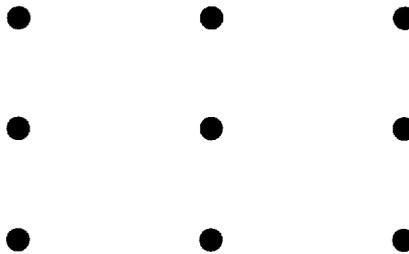
- Ask if a similar project should be started in other villages/communities.
- Thank the community for its valuable participation.

DAY 12

1. THREE KEY MESSAGES

The facilitator reminds participants of the Three Key Messages from the Workshop:

- Participation**
Who decides hand over of the sick?
- Interviewing/listening skills**
When in doubt ask and listen.
- Being creative about solutions**



Join the nine dots using four lines.

2. WORKSHOP EVALUATION

- The facilitator asks the participants to evaluate the Workshop. This may be done several ways. The facilitator leaves the room while the Evaluation is in process:

- Matrix with indicators and a scale

OR

- Venn-previous situation relationships and how present relationships should be (future expectations)

- b. Graffiti sheets
- c. Blank flip charts with questions:
 - What will you do differently as a result of this workshop?
 - What did you like? What changes would you make on our work in the workshop room?
 - What did you like? What changes would you like on work in the community?

3. NEXT STEPS

- a. The facilitator asks the groups (from each Health Center or District) what the next steps are. The group divides into smaller working groups by health center or District to decide and puts their responses on a flipchart.
 - What will your goals be in community partnerships for 1997? What would you have liked to be accomplished by the end of the year?

Number of communities involved.
Number of health workers trained.
Number of plans for implementation.

END OF WORKSHOP